

# The Rule in a Contribution Action Between Third-Party Insurers Wherein the Plaintiff Insurer Seeks Reimbursement of Defense Costs from the Defendant Insurer After a Collusive Fraud on the Plaintiff Insurer Under California Law\*

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## I. INTRODUCTION

The true story of an illegal conspiracy known today as the “Alliance” illustrates how sophisticated and destructive fraud can be.<sup>1</sup> The Alliance was a network of small California law firms that conspired to defraud insurers, apparently bilking them out of an estimated \$200 million.<sup>2</sup> While many Alliance lawyers eventually landed in jail,<sup>3</sup> their clever schemes left a trail of devastation. In the aftermath, a particularly troubling and important legal question arose. This Comment searches for the best answer to that question.

The ultimate issue can be stated as follows: Given that there exists some evidence of a conspiracy involving the insured to defraud its third-

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1. See Don J. DeBenedictis, *The Alliance: Did a Network of Small Southern California Law Firms Conspire to Defraud Insurance Companies to the Tune of \$200 Million?*, 75 A.B.A. J. 58 (Dec. 1989).

2. See *id.* at 59.

3. See Myron Levin, *4th Lawyer Pleads Guilty in Complex Insurance Fraud*, L.A. TIMES, Feb. 17, 1990, at B3.

party insurer,<sup>4</sup> and that there exists at least one co-insurer of equivalent status, under what circumstances can one insurer which undertook a defense of the fraudulent insured (herein called the “payer”) subsequently claim contribution from another insurer (herein called the “non-payer”) for such defense costs under California law?<sup>5</sup> This issue (among others) was recently brought to the California courts, apparently as an issue of first impression, but was avoided by a statute of limitations defense.<sup>6</sup> The issue encompasses sub-issues and requires a thoughtful examination of several related areas of insurance law, including the duty to defend, insurance bad faith, and the law of contribution. Ultimately, the legal rule adopted will have a significant effect on the insurer/insured relationship, the frequency and extent of collusive fraud in our society, the allocation of costs associated with such collusive fraud, and the availability and affordability of insurance generally.

In approaching the ultimate issue, this Comment addresses five sub-issues, as follows:

1. Does or should an insurer have a duty to defend when it “knows” that the insured is involved in collusive fraud?
2. Assuming there is “substantial” but inconclusive evidence of collusive fraud, does an insurer who refuses to defend thereby commit a breach of duty?
3. In connection with a contribution action, are there any “gatekeeper” duties owed by the payer to the non-payer which must be satisfied?
4. Given that the non-payer denied coverage on the basis of collusive fraud, what must be proven in a subsequent contribution action?
5. Assuming that liability must be proven in the contemplated contribution action, which party should have the burden of proof?

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4. I will henceforth refer to such a conspiracy as “collusive fraud.” As used herein, collusive fraud means the knowing involvement of the insured in a conspiracy involving the attempted perpetration of a fraud on the insurer. Such a conspiracy, in the context of third-party insurance, involves the collusion of the insured with either or both of the insured’s counsel and the third-party plaintiff.

5. Notice that the issue is confined to defense costs, the significance of which will become apparent in the discussion of an insurer’s duty to defend and its duty to indemnify.

6. See *New Hampshire Ins. Co. v. National Ben Franklin*, No. BC012590 (Cal. Super. Ct. Feb. 27, 1995), *aff’d*, No. B101206 (Cal. Ct. App. Oct. 29, 1998) (not published).

This Comment is organized as follows: Part II provides the legal and factual background necessary to understand these issues. Part III examines these issues and the various arguments that might attend to each. Part IV offers a proposed resolution of all of these issues. Part V applies the proposed rule to the facts of the post-Alliance contribution action.

## II. BACKGROUND

### A. *Fraud as a Growing Concern*

A recent journal article reveals frightening statistics about fraud in the United States.

In 1985, property and casualty insurance fraud was estimated at \$2 billion per year. That figure has grown significantly over the years. By 1995, property and casualty insurance fraud had risen to \$20 billion, while health care fraud accounted for \$95 billion, each roughly 10 percent of claims paid. In one of the few formal studies conducted, Massachusetts found that 32 percent of the total number of claims studied contained an element of fraud. An Insurance Research Council study estimates that 36 percent of all bodily injury liability claims appear to involve fraud or buildup. It is generally conceded by industry experts that 10 to 25 percent of all property-casualty claims are fraudulent. However, insurers discover only about 20 percent of their fraud problems.

This same source states that fraud is growing in both frequency and sophistication.<sup>8</sup> The insurance industry has responded with various measures to crack down on the problem, "including examinations under oath, independent medical examinations, surveillance, and joint sting operations with law enforcement authorities."<sup>9</sup> Nevertheless, the business of fraud is thriving, apparently ranking second behind the illicit drug industry in terms of illegal revenue.<sup>10</sup> Such fraud takes a staggering economic toll, comparable to "an annual visit by a Hurricane Andrew."<sup>11</sup>

Unfortunately, attorneys are in some cases a part of the problem. The National Insurance Crime Bureau, for example, reports fifty-three fraud charges involving attorneys in 1995 alone.<sup>12</sup> The Alliance demonstrates how vulnerable our society is when crooked attorneys pursue collusive fraud on the insurance industry. This painful truth demands a thoughtful

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7. Edward J. Schrenk & Jonathon B. Palmquist, *Fraud and Its Effects on the Insurance Industry*, 64 DEF. COUNS. J. 23, 23-24 (1997) (citations omitted).

8. *See id.* at 23.

9. *Id.* at 27.

10. *See id.* at 23.

11. *Id.* at 35.

12. *See id.* at 25-26.

response. Given the proclivity for history to repeat itself, we must evaluate and consider refining the legal system in anticipation of the “next Alliance.”

### B. *The Cumis Rule and the Alliance*

The opportunity for attorney fraud received an unintended boost from the 1984 decision of *San Diego Navy Federal Credit Union v. Cumis Insurance Society, Inc.*<sup>13</sup> In that case, an insurer was called upon to defend its insured against a range of claims, some of which were clearly not covered under the insurer’s policy.<sup>14</sup> The insurance company elected to defend under a “reservation of rights.”<sup>15</sup> This meant that the insurer would defend against all the claims, but reserved the right to seek reimbursement for any expenses incurred relative to non-covered claims. The court found that the attorney hired by the insurer to defend the insured faced an impermissible conflict of interest.<sup>16</sup> Under such circumstances, the court held that either the insurer must obtain the informed consent of the insured, or the insurer must provide independent counsel (later termed *Cumis* counsel) to be selected by the insured.<sup>17</sup> Moreover, the court held that control of the independent counsel must rest with the insured.<sup>18</sup> Essentially, *Cumis* held that insurers choosing to defend under a reservation of right must pay the cost of defense, but must also substantially surrender control over the hired attorney.

The *Cumis* rule was subsequently refined and codified by the California legislature in section 2860 of the California Civil Code.<sup>19</sup> Section 2860 provides that, absent an express waiver by the insured, an insurer is required to provide independent counsel whenever the insurer has a duty to defend which involves a conflict of interest.<sup>20</sup> Other provisions include the following: The insurer may require that *Cumis* counsel “possess certain minimum qualifications.”<sup>21</sup> *Cumis* counsel cannot demand a rate of pay greater than customary under the

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13. 208 Cal. Rptr. 494 (Ct. App. 1984).

14. *See id.* at 498.

15. *See id.* at 496.

16. *See id.* at 506.

17. *See id.*

18. *See id.*

19. CAL. CIV. CODE § 2860 (West 1998).

20. *See id.* § 2860(a).

21. *Id.* § 2860(c).

circumstances.<sup>22</sup> *Cumis* counsel and the insurer must disclose to each other all non-privileged information concerning the proceeding or concerning any dispute over insurance coverage, with any claim of privilege being “subject to in camera review.”<sup>23</sup> Both *Cumis* counsel and the insurer’s counsel “shall be allowed to participate in all aspects of the litigation.”<sup>24</sup> Finally, the statute indicates that no provision should be read to diminish any duty of the insured to cooperate with the insurer.<sup>25</sup>

While the *Cumis* doctrine eliminated the evils of a potential conflict of interest, it simultaneously created a fertile breeding ground for fraud. Consider the following story, typical of the many schemes employed by the Alliance.<sup>26</sup> A developer built and sold apartment buildings. Several of these buildings developed problems involving surface cracking. The Alliance saw an opportunity and moved quickly to secure representation. First, one Alliance firm gained representation of the building buyer. This firm carefully crafted claims against the developer, making sure that some portion of these would implicate the developer’s insurance. The developer tendered defense of the suit to its insurer. The insurer elected to defend under a reservation of rights and informed the developer of his right to select counsel of his choice. Meanwhile, another Alliance firm was waiting in the wings. This firm finagled its appointment as the developer’s *Cumis* counsel by actually *paying* the developer for the opportunity.<sup>27</sup> From this point or earlier, the developer had become an accomplice in the Alliance scheme.

Having secured representation of both sides to the controversy, and, enjoying substantial freedom from oversight by the insurer, the Alliance proceeded to implement its criminal plan. Early in the proceedings, the Alliance joined numerous additional parties to the litigation, with Alliance firms securing representation whenever possible. A flurry of counterclaims and cross-claims ensued. Then came an extensive and protracted discovery phase. The Alliance took every opportunity to complicate and ensnarl matters, and consistently over-billed both hours and rates. In one noteworthy case, these tactics apparently produced \$10 million in defense bills on a case that eventually settled for \$1.5 million.<sup>28</sup> Whenever the insurer would inquire about the legitimacy of

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22. *See id.*

23. *Id.* § 2860(d).

24. *Id.* § 2860(f).

25. *See id.*

26. *See* DeBenedictis, *supra* note 1, at 59-65; Levin, *supra* note 3, at B3; Interview with Robert K. Schraner, in San Diego, Cal. (Aug. 18, 1998). Schraner was defense counsel in the post-Alliance contribution action cited *supra* note 6.

27. Apparently, payoff of the client was not uncommon. *See* DeBenedictis, *supra* note 1, at 61.

28. *See* DeBenedictis, *supra* note 1, at 61.



legal bills, the *Cumis* counsel would respond evasively, often invoking the attorney-client privilege.<sup>29</sup>

Furthermore, the Alliance found it could intimidate insurers rather easily. Whenever an insurer would challenge the work or billings of an Alliance firm, the firm would quickly respond with threats of bad faith litigation.<sup>30</sup> These tactics were remarkably effective, as insurance companies were unwilling to risk bad faith exposure. One success built on another, and the Alliance expanded—both in the number of attorney participants and in the number of cases infiltrated. The Alliance adopted a hierarchical structure similar to other organized crime, with the kingpin apparently receiving sixty percent of all Alliance revenues.<sup>31</sup> Eventually, however, the extraordinary greed of the Alliance proved to be its downfall. The billings became so outrageous that some insurers eventually became suspicious of an organized, fraudulent conspiracy. Those insurers began sharing data to piece together the pattern of abuse.<sup>32</sup> A tip from an attorney who was solicited by the Alliance led to the placement of an undercover attorney within Alliance circles.<sup>33</sup> After almost two years, a painstaking investigation led to the criminal prosecution and conviction of many Alliance members.<sup>34</sup> An episode of unprecedented fraud on insurance companies finally came to an end.<sup>35</sup>

The interesting legal issue arising from the aftermath of the Alliance fraud proceeds from the refusal of one insurance company (the non-

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29. See *id.* at 62.

30. See Interview with Robert K. Schraner, *supra* note 26.

31. See DeBenedictis, *supra* note 1, at 65.

32. See *id.*

33. See *id.* at 59.

34. See Levin, *supra* note 3, at B3.

35. An apt summary of the Alliance can be seen in the appellate court's decision affirming the conviction of the leader of the Alliance. The court wrote,

[I]t was established at trial that Stites had been the mastermind of a massive set of breaches of professional responsibility and of the criminal law, the more heinous because Stites was a lawyer and at least twelve other lawyers were his principal confederates in carrying out the fraud. The mentality that sees law as a business was here taken to a *reductio ad absurdum*—litigation was unconscionably churned to make money for the lawyers. The essence of Stites's scheme, repeated over and over again, was for Stites to control both sides of suits in which insurance companies were paying for counsel, and to assure that the plaintiffs' lawyers would not settle until the insurance companies would no longer pay the costs of defendants' counsel. Stites's network of lawyers was known as "the Alliance." According to the jury verdict in this case, Stites's scams extracted at least \$50 million from the insurers in the period 1984 to 1987.

*United States v. Stites*, 56 F.3d 1020, 1022 (9th Cir. 1995).

payer) to defend.<sup>36</sup> Alliance firms had demanded that the non-payer defend under circumstances very similar to those described above. The non-payer refused, claiming that there was little evidence to support any legitimate claim. Other insurers (the payers) felt compelled by the law and the circumstances to defend under a reservation of rights. A few years after so defending, the payers sought contribution of defense costs from the non-payer.<sup>37</sup> The non-payer refused, claiming that there was substantial evidence at the time of the original claims to indicate that these claims were not legitimate.<sup>38</sup> The payers insisted, however, that the non-payer could not have known (or at least did not know) this at the time, and therefore was not justified in refusing to defend.<sup>39</sup> The payers and the non-payer were not able to come to terms, and the payers brought suit.<sup>40</sup>

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36. See Interview with Robert K. Schraner, *supra* note 26.

37. While the payers sought contribution for both defense costs and the cost of settlement, this Comment only concerns the contribution concerning defense costs.

38. Accordingly, the brief for the defendant non-payer in the actual contribution action states,

In essence, rather than investigating the claims which would have revealed what was going on at the outset and examining and auditing defense bills as they came in (which would have quickly revealed their impropriety and the nature of the scam being run), [the payers] chose simply to pay the bills in their entirety and pass them through to the public paying their insurance premiums or, alternatively, to other insurers. . . . [T]hese insurers would have the judicial system make [the non-payer] responsible for their mistakes and the ultimate banker for the Alliance's fraudulent activities.

Mediation Brief for U.S. Fire Ins. Co. at 21-22, *New Hampshire Ins. Co. v. National Ben Franklin*, No. BC012590 (Cal. Super. Ct. Feb. 27, 1995), *aff'd*, No. B101206 (Cal. Ct. App. Oct. 29, 1998) (not published) (emphasis omitted). While the non-payer's brief does not explicitly allege the knowing involvement of the insured, such an explicit allegation by the non-payer constitutes a critical and limiting assumption of this Comment.

39. Accordingly, the brief for the plaintiff payers in the actual contribution action states,

[The non-payer] had the duty to defend the underlying cross-complaints . . . . [It] now criticizes the manner in which [the payers] undertook their contractual defense obligations. [It] has the audacity to claim that [the payers] cannot establish the reasonableness of the defense billings . . . even though [the non-payer] rejected the opportunity to participate in and direct the defense of those same cross-complaints.

[The non-payer] apparently believes that its breach and refusal to assume its contractual obligations to defend these cross-complaints now allows it to apply 20/20 hindsight to those carriers who properly took up the burden in [the non-payer's] stead.

Mediation Brief for New Hampshire Ins. Co. at 24, *New Hampshire Ins. Co. v. National Ben Franklin*, No. BC012590 (Cal. Super. Ct. Feb. 27, 1995), *aff'd*, No. B101206 (Cal. Ct. App. Oct. 29, 1998) (not published).

40. See *New Hampshire Ins. Co. v. National Ben Franklin*, No. BC012590 (Cal. Super. Ct. Feb. 27, 1995), *aff'd*, No. B101206 (Cal. Ct. App. Oct. 29, 1998) (not published). In this case, the payers sought reimbursement for both defense and indemnity. As mentioned, this Comment only concerns the claim for reimbursement of

C. *The Duty to Defend*

This section will begin with a brief discussion regarding terminology. Insurance policies take two forms—liability policies and indemnity policies.<sup>41</sup> According to Black's Law Dictionary, "Liability insurance is that form of insurance which indemnifies against *liability* on account of injuries to the person or property of another."<sup>42</sup> Indemnity policies, on the other hand, provide "indemnity against *loss*,"<sup>43</sup> with "indemnity" meaning "reimbursement."<sup>44</sup> A federal court explained, "A liability policy provides coverage for a loss which the insured becomes legally obligated to pay, whereas an indemnity policy provides coverage only for those losses actually paid out by the insured."<sup>45</sup> Accordingly, indemnity policies protect insureds only through reimbursement for specific losses actually incurred.<sup>46</sup> Indemnity policies can be third-party insurance (affording protection against third-party claims) or they can be first-party insurance (as in the case of a homeowner's fire insurance, for example).<sup>47</sup> Both liability policies and indemnity policies which cover third-party claims are presumed to cover legal defense costs for covered claims but can be drafted to exclude such defense coverage.<sup>48</sup> Note that an indemnity policy that provides for reimbursement of defense costs does not thereby necessarily impose a duty to defend on the insurer.<sup>49</sup> The term "indemnify"—not to be confused with "indemnity"—means "[t]o restore the victim of a loss, in whole or in part, by payment, repair, or replacement."<sup>50</sup> When an insured suffers an insurable loss, the insurer assumes a duty to indemnify, regardless of the insurance form—liability or indemnity.

The critical variable in the various policy forms available, for

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*defense costs.* However, a favorable outcome on this issue for the non-payer would generally preclude any liability for indemnity contribution—for reasons that will become apparent.

41. See *Save Mart Supermarkets v. Underwriters at Lloyd's London*, 843 F. Supp. 597, 603 (N.D. Cal. 1994).

42. BLACK'S LAW DICTIONARY 805 (6th ed. 1990) (emphasis added).

43. *Id.* at 804 (emphasis added).

44. *Id.* at 769.

45. *Save Mart Supermarkets*, 843 F. Supp. at 603.

46. See *id.*

47. See KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 179 (2d ed. 1995).

48. See *Save Mart Supermarkets*, 843 F. Supp. at 602-03.

49. See *id.* at 603.

50. BLACK'S LAW DICTIONARY 769 (6th ed. 1990).

purposes of this Comment, is the role of the insurer regarding the defense of the insured in the event of a third-party claim. An example may be helpful. Suppose that Bill, Jane, Fred, and Mary each buy insurance to protect their separate business endeavors. Bill buys liability insurance which includes coverage for defense costs. Jane buys liability insurance that does not cover defense costs. Fred buys indemnity insurance which includes coverage of defense costs. Finally, Mary buys indemnity insurance which excludes defense costs. Suppose Jack, a third party, is injured in an incident for which all of the four insureds were arguably negligent and may be personally liable. Assume also that the alleged negligence is covered under all four policies. How will the various policies work? Bill's insurer will assume responsibility for Bill's defense, securing and paying counsel and other defense costs. Jane must provide her own defense and will not be reimbursed for defense costs. Fred must conduct and pay for his own defense, but will be reimbursed for such costs. Finally, Mary must conduct and pay for her own defense, with no right of reimbursement. All four insureds have the same protection in the event that damages are awarded to Jack. Ultimately, the critical distinction is whether the insured or the insurer directly bears the responsibility and expense of mounting a competent defense. Under those scenarios where the insurer bears this burden, the insurer is said to have the duty to defend.

The foregoing discussion serves to outline the theoretical configurations of third-party insurance. In reality, most third-party insurance policies are liability policies, and these virtually always include defense coverage.<sup>51</sup> Moreover, an ambiguous liability policy will be deemed to include defense coverage.<sup>52</sup> However, the exact limit of the duty to defend can become unclear when a claim arises which is arguably completely outside the policy coverage. The California Supreme Court addressed this issue in the 1966 case, *Gray v. Zurich Insurance Co.*<sup>53</sup> In *Gray*, a third party sued the insured for assault and battery relating to an altercation between motorists. After the insured lost the suit, he sued the insurer which had refused to defend on the grounds that the nature of the claim fell within an exclusion for bodily injury "caused intentionally by . . . the insured."<sup>54</sup> While the trial court ruled for the insurer, the California Supreme Court reversed, holding that the insurer breached its duty to defend.<sup>55</sup> The court reasoned that the

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51. See ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW § 111(a), at 729 & n.1 (2d ed. 1996).

52. See *Save Mart Supermarkets*, 843 F. Supp. at 602.

53. 419 P.2d 168 (Cal. 1966).

54. *Id.* at 174.

55. See *id.* at 171.

policy was sufficiently ambiguous to support a reasonable expectation of defense coverage in such a suit.<sup>56</sup> The court went on to explain why the duty to defend and the duty to indemnify do not always go hand in hand.

At the threshold we note that the nature of the obligation to defend is itself necessarily uncertain. Although insurers have often insisted that the duty arises only if the insurer is bound to indemnify the insured, this very contention creates a dilemma. No one can determine whether the third party suit does or does not fall within the indemnification coverage of the policy until that suit is resolved; in the instant case, the determination of whether the insured engaged in intentional, negligent or even wrongful conduct depended upon the judgment in the [third party] suit, and, indeed, even after that judgment, no one could be positive whether it rested upon a finding of plaintiff's negligent or his intentional conduct. The carrier's obligation to indemnify inevitably will not be defined until the adjudication of the very action which it should have defended.<sup>57</sup>

Current California law concerning the duty to defend was summarized in the 1996 case of *Maryland Casualty Co. v. National American Insurance Co. of California*.<sup>58</sup> The court wrote,

The defense duty is not contingent upon indemnity liability, but is determined at the outset of the underlying action by comparing the policy provisions with the complaint allegations and any relevant extrinsic evidence to determine if there is any potential of coverage under the policy. If there is, a defense is owed even where ultimately it is determined there was no coverage and therefore no indemnity liability.<sup>59</sup>

Thus, the courts have held that, if there is any potential for coverage, the insurer has a duty to defend.<sup>60</sup> Also, as indicated, the duty cannot be determined with the benefit of hindsight.<sup>61</sup> But, extrinsic evidence can and should be used to prove or disprove the potential for coverage.<sup>62</sup> Note also that the duty to defend generally also protects the insured against "groundless, false, or fraudulent claims."<sup>63</sup> A 1998 case citing

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56. *See id.*

57. *Id.* at 173 (citation omitted).

58. 56 Cal. Rptr. 2d 498 (Ct. App. 1996).

59. *Id.* at 501.

60. *See Vann v. Travelers Cos.*, 46 Cal. Rptr. 2d 617, 620 (Ct. App. 1995) (holding that, where there is the potential for coverage, summary judgment for the insurer on the issue of coverage or the duty to defend is inappropriate).

61. *See A-H Plating, Inc. v. American Nat'l Fire Ins. Co.*, 67 Cal. Rptr. 2d 113, 116 (Ct. App. 1997).

62. *See Montrose Chem. Corp. v. Superior Court*, 861 P.2d 1153, 1159-60 (Cal. 1993).

63. *Remmer v. Glens Falls Indem. Co.*, 295 P.2d 19, 20 (Cal. Ct. App. 1956); *Horace Mann Ins. Co. v. Barbara B.*, 846 P.2d 792, 799 (Cal. 1993).

*Gray* emphasized that the insurer must overcome a heavy burden, explaining, "The duty to defend is excused only 'if the third party complaint can by no conceivable theory raise a single issue which could bring it within the policy coverage.'"<sup>64</sup> Finally, note that the duty to defend might arise by estoppel. Estoppel arises, for example, when an insurer defends without a timely reservation of rights.<sup>65</sup> Thus, an insurer originally having no duty to defend can actually bring such an obligation upon itself by commencing a defense without making a reservation of rights.

Modern cases concerning the duty to defend have produced "rules of interpretation" to clarify an insurer's obligation in difficult or "borderline" cases. These rules generally give the benefit of any doubt to the insured. First, the complaint against the insured will be "liberally construed."<sup>66</sup> Second, ambiguous language in the written insurance policy will be construed against the drafter of the policy—invariably the insurer.<sup>67</sup> Third, where appropriate, an insurance policy may be viewed as an adhesion contract, and in such cases the reasonable expectation of the insured will prevail over the express terms of the policy.<sup>68</sup> In any

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64. *Charles E. Thomas Co. v. Transamerica Ins. Group*, 72 Cal. Rptr. 2d 577, 579 (Ct. App. 1998) (emphasis omitted) (quoting *Montrose Chem. Corp. v. Superior Court*, 861 P.2d 1153, 1160 (Cal. 1993) (quoting *Gray v. Zurich Ins. Co.*, 419 P.2d 168, 176 n.15 (Cal. 1966))). Note that this case has taken some liberty in construing precedent. The original words in *Gray*, and the later quotation in *Montrose*, did not say "only."

65. A 1980 California case cited precedent which states,

The general rule supported by the great weight of authority is that if a liability insurer, with knowledge of a ground of forfeiture or noncoverage under the policy, assumes and conducts the defense of an action brought against the insured, without disclaiming liability and giving notice of its reservation of rights, it is thereafter precluded in an action upon the policy from setting up such ground of forfeiture or noncoverage. In other words, the insurer's unconditional defense of an action brought against its insured constitutes a waiver of the terms of the policy and an estoppel of the insurer to assert such grounds.

*Miller v. Elite Ins. Co.*, 161 Cal. Rptr. 322, 331 (Ct. App. 1980) (quoting *Insurance Co. of N. Am. v. Atlantic Nat'l Ins. Co.*, 329 F.2d 769, 775-76 (4th Cir. 1964)).

Estoppel might also arise from bad faith. Accordingly, a Washington case held that an insurer is estopped to deny coverage to an insured where the insurer has commenced a defense and has proceeded to conduct the defense in a manner demonstrating bad faith. See *Safeco Ins. Co. v. Butler*, 823 P.2d 499, 505 (Wash. 1992).

66. *Michaelian v. State Compensation Ins. Fund*, 58 Cal. Rptr. 2d 133, 140 (Ct. App. 1996). This rule makes sense given that modern pleading rules are generally liberal, permitting claims that merely suggest a cause of action in vague, imprecise, or incomplete language.

67. See ROBERT KEETON & ALAN WIDISS, *INSURANCE LAW* § 6.3, at 628-29 (Student ed. 1988).

68. See *Gray*, 419 P.2d at 171-72. The author of a treatise on insurance law has attempted to explain the possible legal bases for the doctrine of reasonable expectations, as follows.

When the insured's expectation is created by some kind of ambiguity or

case, the final determination of the duty to defend is said to be a matter of law for the courts to decide.<sup>69</sup>

In some cases, an insured faces a mix of claims, with some falling within insurance coverage and some falling outside insurance coverage. In such a circumstance, the courts have determined that the insurer has a duty to defend against all claims, covered or not, but may be reimbursed for defense costs clearly and solely attributable to non-covered claims.<sup>70</sup> This right of reimbursement may be quite illusory, however, as the following excerpt from one commentator suggests.

As a general rule, where an insurer has a duty to defend, it must defend all allegations if any claim is potentially covered under the policy. The only exception to this general rule is where the expenses are clearly allocable. In order to establish allocability, the insurer must produce "undeniable evidence supporting an allocation of a specific portion of the defense costs to a noncovered claim." This ["undeniable evidence"] requirement is extremely difficult to meet and will very rarely warrant the allocation of defense expenses. In fact, in those cases which discuss this exception to the rule of a full defense, no insurer has been able to meet the requirements outlined by the court to obtain such an allocation.

Thus, while reimbursement for non-covered claims is theoretically obtainable, reimbursement will be denied in most cases due to the impracticability of apportionment.<sup>72</sup>

The discussion above might suggest that an insurer's duty to defend

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vagueness in the policy's language, syntax, or organization, something like the doctrine of *contra proferentum* (construe the writing against the drafter) is operating. When the insured's expectation comes from some assertion by an agent of the insurer or through the insurer's advertising, something like the doctrine of misrepresentation or deceit is operating. When the insured's expectation is grounded in an assumption that coverage for the loss in question would exist given the amount of premium charged, something like the doctrine of unconscionability is operating. When the insured's expectation is part and parcel of the insured's sudden surprise and dismay at the absence of coverage, something like the doctrine of mistake is operating. When the insured's expectation comes from the insurer's invitation to the insured to place trust in the insurer that the insured's coverage needs will be satisfactorily met, something like an estoppel or reliance theory is operating.

JERRY, *supra* note 51, § 25D, at 144-45 (footnotes omitted).

69. See *Interinsurance Exch. of the Auto. Club of S. Cal. v. Flores*, 53 Cal. Rptr. 2d 18, 20-21 (Ct. App. 1996).

70. See *Buss v. Superior Court*, 939 P.2d 766, 775-78 (Cal. 1997).

71. Lynn Haggerty King & Heidi Loken Benas, *The Duty to Defend: When Does It Exist and What Damages Are Recoverable for Its Breach?*, 7 U.S.F. MAR. L.J. 245, 261 (1994) (citations omitted).

72. See *Gon v. First State Ins. Co.*, 871 F.2d 863, 868-69 (9th Cir. 1989).

has no limit. Modern courts, however, have held otherwise.<sup>73</sup> Where a claim clearly falls beyond all areas of coverage, the insurer has no duty to defend.<sup>74</sup> Stated differently, where there is no potential for coverage, there is no duty to defend.<sup>75</sup> Accordingly, courts have often found that there is no duty to defend what is purely an intentional act when policy language clearly confines coverage to “accidents.”<sup>76</sup> Thus, even though an insurance policy may specifically provide protection against groundless and fraudulent claims, the duty to defend is still limited to “actions of the nature and kind covered by the policy.”<sup>77</sup> Note also that public policy can preclude coverage (e.g., for criminal activity), thereby ruling out any duty to defend.<sup>78</sup> Finally, notwithstanding the favored status of the insured, the California Supreme Court in 1995 rejected an assertion that uncertainty—either regarding policy coverage or regarding a legal question—alone gives rise to the duty to defend.<sup>79</sup>

Absent a contractual provision to the contrary, insurers do not enjoy a grace period whereby the duty to defend is held in abeyance pending an investigation to determine the validity of claims.<sup>80</sup> In so holding, the courts have expressed a concern that affording any such grace period would discourage insurers from promptly fulfilling their contractual duties.<sup>81</sup> A California court explained as follows:

“[T]he duty to defend begins when a potential for coverage arises, and the duty continues until the insurer proves otherwise. . . . [A] declaratory judgment of no coverage, either by summary judgment or after trial, does not retroactively relieve the . . . insurer of the duty to defend. It only relieves the insurer of the obligation to continue to defend after the declaration.”<sup>82</sup>

The same court went on to explain,

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73. See *Waller v. Truck Ins. Exch.*, 900 P.2d 619, 628 (Cal. 1995); *Gray v. Zurich Ins. Co.*, 419 P.2d 168, 175 (Cal. 1966).

74. See *Gray*, 419 P.2d at 176 n.15.

75. See *Oliver Mach. Co. v. United States Fidelity & Guar. Co.*, 232 Cal. Rptr. 691, 696 (Ct. App. 1986).

76. See *Dykstra v. Foremost Ins. Co.*, 17 Cal. Rptr. 2d 543, 543-45 (Ct. App. 1993). The court wrote, “Since insurance is designed to protect against contingent or unknown risks of harm, rather than harm that is certain or expected, it is well settled that intentional or fraudulent acts are deemed purposeful rather than accidental and, therefore, are not covered under a [commercial general liability] policy.” *Id.* at 545 (citations omitted).

77. *Gray*, 419 P.2d at 175.

78. See *Waller*, 900 P.2d at 626.

79. See *id.* at 632.

80. See *Scottsdale Ins. Co. v. American Empire Surplus Lines Ins. Co.*, 791 F. Supp. 1079, 1086 (D. Md. 1992).

81. See *id.*

82. *Haskel, Inc., v. Superior Court*, 39 Cal. Rptr. 2d 520, 527-28 (Ct. App. 1995) (emphasis omitted) (quoting *Hartford Accident & Indem. Co. v. Superior Court*, 29 Cal. Rptr. 2d 32, 35-36 (Ct. App. 1994)).



Such a rule does not unfairly burden an insurer who disputes coverage. While an insured may obtain an early summary adjudication of a defense obligation, the insurer is entitled to seek a contrary ruling at any time it acquires the requisite evidence to conclusively eliminate any potential for coverage.

There are several possible grounds for withdrawal by the insurer after the duty to defend has attached.<sup>84</sup> First, the insurer that has reserved the right to withdraw upon a determination of non-coverage may do so when it subsequently establishes such non-coverage.<sup>85</sup> Note, however, that an insurer defending in a "mixed" case, involving both covered and non-covered claims, cannot always withdraw after the covered claims are settled—at least where the insured reasonably expects continued coverage.<sup>86</sup> Note also that when termination is based on a determination of non-coverage, the evidence of non-coverage must consist of "undisputed facts which conclusively eliminate a potential for liability."<sup>87</sup> Second, the insurer may withdraw if it has been prejudiced by the substantial and material non-cooperation of the insured.<sup>88</sup> Third, there is some support for the proposition that the insurer may withdraw once it exhausts the indemnity limit in the policy, but only when the policy clearly so provides.<sup>89</sup>

The remedies for breach of the duty to defend have been summarized in a legal journal, as follows:

At the least, an insurer's erroneous refusal to furnish a defense will constitute a breach of contract. Under a contract measure of damages, the insured is entitled to receive only those amounts due under the policy plus any other consequential damages foreseeable when the contract was entered into. "Where there is no opportunity to compromise the claim and the only wrongful act of the insurer is the refusal to defend, the liability of the insurer is ordinarily limited to the amount of the policy plus attorneys' fees and costs."

If there is a determination that only the duty to defend was breached, and there was in fact no obligation to indemnify the underlying claim, the insured's damages may be limited to those costs incurred in defense of the underlying suit. These consequential damages will include litigation expenses, attorneys' fees and other defense costs.

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83. *Id.* at 528.

84. *See* King & Benas, *supra* note 71, at 262.

85. *See id.*

86. *See* Ohio Cas. Ins. Co. v. Hubbard, 208 Cal. Rptr. 806, 811 (Ct. App. 1984).

87. Montrose Chem. Corp. v. Superior Court, 861 P.2d 1153, 1160 (Cal. 1993).

88. *See* Valladao v. Fireman's Fund Indem. Co., 89 P.2d 643, 647 (Cal. 1939).

89. *See* JERRY, *supra* note 51, § 111(2), at 746-50. Jerry cautions, however, "Currently, the question of whether the duty to defend can be discharged by fulfilling the duty to indemnify is a confused one in insurance law." *Id.* at 750.

90. King & Benas, *supra* note 71, at 264-65 (citations omitted) (quoting Comunale

The same article goes on to discuss the extra-contractual liability which can arise if the court finds a breach of the implied covenant of good faith and fair dealing.<sup>91</sup> This area of the law is discussed below in Part II.D.

Finally, note that, once the duty to defend is found to apply, the insurer may be required to provide *Cumis* counsel, as previously discussed in Part II.B.<sup>92</sup>

#### D. Bad Faith Law

##### 1. Introduction

There is an implied duty of good faith and fair dealings that applies universally to all contracts.<sup>93</sup> Accordingly, an insurance policy, a form of contract, imposes such a duty on both the insurer and the insured.<sup>94</sup> In general, breach of this duty by an insurer constitutes “bad faith.”<sup>95</sup> A

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v. Traders & Gen. Ins. Co., 328 P.2d 198, 201 (Cal. 1958)).

91. See *id.* at 265.

92. See *infra* Part II.B.

93. See U.C.C. § 1-203 (1978); RESTATEMENT (SECOND) OF CONTRACTS § 205 (1981).

94. See Douglas R. Richmond, *An Overview of Insurance Bad Faith Law and Litigation*, 25 SETON HALL L. REV. 74, 128 (1994) [hereinafter Richmond, *An Overview*].

95. See BLACK'S LAW DICTIONARY 139 (6th ed. 1990) (citing *Blue Cross & Blue Shield v. Grainger*, Ala., 461 So. 2d 1320, 1327 (Ala. 1984)); see also *Safeco Ins. Co. v. Guyton*, 692 F.2d 551, 557 n.7 (9th Cir. 1982). This definition should be qualified by the comment of a treatise author on insurance law, who wrote, “Indeed, ‘good faith’ and ‘bad faith’ remain elusive concepts with no universally accepted definition.” JERRY, *supra* note 51, § 25G, at 151. Note, in particular, that in California the *Black's* definition of bad faith may be inadequate, for reasons discussed in the ensuing paragraph of the main text.

Perhaps an understanding of bad faith and its relevancy to the issues of this Comment can be advanced by Figure A, *infra* page 816. The diagram depicts a continuum representing the certainty of the obligation to perform (i.e., to defend, settle, or indemnify) under various factual circumstances. In the area depicted by the left side of the diagram, there is great certainty that, under the law, the insured's demand on the insurer would not prevail. This outcome might reflect either an absence of coverage or a policy deemed to have become void. Thus, an insurer is fully justified in denying coverage in the “Clearly no duty to perform” zone. In the zone depicted in the middle and labeled the “gray area,” there is genuine uncertainty as to the insurer's legal obligation. This uncertainty might involve a factual question, a legal question, or some combination of the two. Denial of coverage by the insurer in the gray area raises potentially difficult legal issues. Finally, in the area depicted by the right side of the diagram, there is great certainty, under the law, that the insured's demand on the insurer must prevail. Failure by the insurer to perform in the “Clearly a duty to perform” zone would generally constitute bad faith. See, e.g., *Rawlings v. Apodaca*, 726 P.2d 565, 572 (Ariz. 1986) (stating that an insurer's rejection of a claim demonstrates bad faith unless coverage is “fairly debatable”).

Bad faith law is relevant to the contemplated contribution action only because of the overlap of issues involved in bad faith and the duty to defend. These include the

cause of action for bad faith traditionally lay in contract.<sup>96</sup> More recently, however, the offense has been characterized as a tort, significantly enhancing the damages available.<sup>97</sup> The modern characterization reflects the view that contractual remedies may be inadequate to deter coercion of the insured by the insurer.<sup>98</sup> As one court explained,

When coverage and liability are established . . . a game of the strong against the weak *can* begin. A . . . valid and legitimate [claim] can be settled for far less than its actual value if the need for funds by the victim is great enough and the insurance company is obstinate enough to use its knowledge of that fact to force acceptance of a lesser sum.

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following: (1) Is there a "gray area" at all? (2) If there is a "gray area," what are its boundaries? (3) To what extent does the insurer enjoy the discretion to deny coverage in the "gray area"? (4) When, if ever, will an insurer commit bad faith in denying coverage in the "gray area"? (5) What extracontractual penalties might be imposed for the wrongful denial of coverage in the "gray area"? (6) To what extent does the threat of bad faith provide an effective incentive to an insurer to perform according to its duty? And, finally, (7) Under what circumstances can a bad-faith breach of the duty to defend trigger liability also for a breach of the duty to settle and the duty to indemnify? These questions are implicit in the discussion in Part III and Part IV.

96. See Richmond, *An Overview*, *supra* note 94, at 77.

97. See *id.*

98. See *id.* at 78. Commentators have debated the merit of this view. For a brief summary of the debate, see JERRY, *supra* note 51, § 25G, at 155.

99. Richmond, *An Overview*, *supra* note 94, at 79 (alteration in original) (citation omitted) (quoting *Holmgren v. State Farm Mut. Auto. Ins. Co.*, 976 F.2d 573, 578 (9th Cir. 1992)). Some interesting analogies might be drawn between bad faith law and products liability law. (1) Causes of action in both areas have their genesis in a contractual context, but have nonetheless evolved into independent torts. (The tort characterization of products liability can be traced to the landmark case of *MacPherson v. Buick Motor Co.*, 111 N.E. 1050 (N.Y. 1916).) (2) The arguments offered for the tort-characterization of bad faith resemble those offered for the tort-characterization of products liability. Accordingly, in both contexts, the arguments refer to problems of externalities, poorly informed consumers, and unequal bargaining power. (3) In both areas, the law has developed strong presumptions in favor of the victim. (4) A bad faith claim might be characterized as a products liability claim, with the defective product being the insurance policy. Interestingly, a few cases have invoked the theory of the implied warranty of fitness within an insurance context. See JERRY, *supra* note 51, § 25F, at 150-51. (5) In both areas, the legitimate question arises as to whether contract law is actually inadequate and, if so, why. Stated in terms used by "law and economics" scholars: Is there a market failure that demands corrective intervention? For such a discussion in the context of bad faith, see Alan O. Sykes, "*Bad Faith*" *Breach of Contract By First Party Insurers*, 25 J. LEGAL STUD. 405, 416-21 (1996). (6) Likewise, in both areas the law must implicitly decide which tort regime prevails—joint care or alternative care. (As explained in lectures by Professor Christopher Wonnell at the University of San Diego, the joint care regime should prevail when avoidance of the

FIGURE A

INSURER'S DUTY TO DEFEND, SETTLE, OR INDEMNIFY

Clearly no duty to perform	Duty to perform is unclear	Clearly a duty to perform
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Denial of coverage  
does not constitute  
bad faith

"Gray area"

Denial of coverage  
constitutes  
bad faith

California case law suggests that there are three categories of insurer misconduct. The first is a breach of the duty of good faith and fair dealing that falls short of the more reprehensible conduct connoted by "bad faith." The California Supreme Court in 1975 explained,

Several cases, in considering the liability of the insurer, contain language to the effect that bad faith is the equivalent of dishonesty, fraud, and concealment. . . . The language used in the cases, however, should not be understood as meaning that in the absence of evidence establishing actual dishonesty, fraud, or concealment no recovery may be had for a judgment in excess of the policy limits. . . . Liability [may be] imposed not [only] for a bad faith breach of the contract<sup>100</sup> but [also] for failure to meet the duty to accept reasonable settlements . . . .

A few months later, the same court wrote, "[A]n insurer's 'good faith,' though erroneous, belief in noncoverage affords no defense to [extra-contractual] liability flowing from the insurer's refusal to accept a reasonable settlement offer."<sup>101</sup> Thus, in California, extra-contractual

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harm is achieved most efficiently by requiring both the plaintiff and the defendant to take precautions. By contrast, an alternative care regime should prevail when avoidance of the harm is achieved most efficiently by requiring only one party—the lowest-cost avoider—to take appropriate precautions.) Stated differently, the question is whether an optimal legal rule should produce incentives affecting plaintiff behavior. Again, Sykes addresses this issue in connection with bad faith, questioning whether the prevailing bad-faith regime "does little to police misconduct while doing much to cause uneconomic increases in the premiums that policyholders must pay." *Id.* at 443.

100. *Crisci v. Security Ins. Co.*, 426 P.2d 173, 176-77 (Cal. 1967).

101. *Johansen v. California State Auto. Ass'n Inter-Ins. Bureau*, 538 P.2d 744, 748 (Cal. 1975). Note that the extra-contractual liability for failure to accept a reasonable

liability normally associated with bad faith can attach even in the absence of bad faith.<sup>102</sup> Commentators analyzing bad faith have sidestepped this inconvenient result by characterizing such lesser offenses as negligence-based bad faith.<sup>103</sup> This approach appears to be both accurate and sensible, and will be adopted herein.

Two other categories of insurer misbehavior (in addition to negligence-based bad faith) can be deduced from a case<sup>104</sup> that explained section 3294 of the California Civil Code as follows: "In order to establish that an insurer's conduct has gone sufficiently beyond mere bad faith to warrant a punitive award, it must be shown by *clear and convincing evidence* that the insurer has acted maliciously, oppressively or fraudulently."<sup>105</sup> This Comment will refer to bad faith warranting punitive damages as "MOF bad faith" (MOF deriving from "maliciously, oppressively or fraudulently"). This Comment will refer to the "mere" bad faith not warranting punitive damages as "knowing bad faith." Having deduced and labeled these three categories—negligent bad faith, knowing bad faith, and MOF bad faith—this Comment will henceforth speak of the "severity" of bad faith by reference to one of these three categories.

Insurer bad faith can occur in the context of either first-party insurance or third-party insurance.<sup>106</sup> Third-party insurance is liability or indemnity insurance that affords protection in the event of liability to a third party.<sup>107</sup> First-party insurance, by contrast, is indemnity insurance that protects the insured against hazards such as ill health, property damage, or property loss.<sup>108</sup> Insurer bad faith occurring in the context of first-party insurance is sometimes called "first-party bad faith"; likewise, that occurring in the context of third-party insurance is sometimes called "third-party bad faith."<sup>109</sup> Note, however, that this terminology is not

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settlement offer consists of a lifting of the policy limits. *See Brown v. Guarantee Ins. Co.*, 319 P.2d 69, 70-71 (Cal. Ct. App. 1957); *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 201 (Cal. 1958).

102. *See Richmond, An Overview*, *supra* note 94, at 98 (citing *Mock v. Michigan Millers Mut. Ins. Co.*, 5 Cal. Rptr. 2d 594, 607 (Ct. App. 1992)).

103. *See Richmond, An Overview*, *supra* note 94, at 98; *see also Sykes, supra* note 99, at 411.

104. *Mock*, 5 Cal. Rptr. 2d 594.

105. *Id.* at 607.

106. *See Richmond, An Overview*, *supra* note 94, at 80.

107. *See id.*

108. *See id.* at 103.

109. *Id.*

used consistently and in any case may be misleading. The terminology is subject to inconsistent use because a court or a commentator will sometimes refer to any allegation of bad faith made by the insured against the insurer as first-party bad faith.<sup>110</sup> The terminology is misleading because “third-party bad faith” seems to erroneously suggest a cause of action generally enjoyed by third-party plaintiffs.<sup>111</sup> In fact, a third party generally has no private right of action against an insurer under California law.<sup>112</sup> In the interest of clarity, this Comment will speak of “third-party-insurance bad faith” and “first-party-insurance bad faith.”

## 2. Third-Party-Insurance Bad Faith

A third-party-insurance bad faith action can potentially arise from a breach of the duty to defend, the duty to indemnify, or the duty to settle.<sup>113</sup> The genesis of the modern California tort of third-party-insurance bad faith can be traced to *Brown v. Guarantee Insurance Co.*,<sup>114</sup> a 1957 case involving a breach of the duty to settle. Brown sued Weisenberg for damages arising from an automobile accident.<sup>115</sup> Guarantee Insurance Company assumed the defense of Weisenberg, its insured, but refused Brown’s offer to settle for \$5000.<sup>116</sup> Subsequently, a jury awarded Brown \$15,000 in damages, after which Guarantee paid the policy limit of \$5000 to Brown.<sup>117</sup> Weisenberg was unable to pay the balance of the judgment and declared bankruptcy.<sup>118</sup> The bankruptcy court assigned any rights of Weisenberg under the Guarantee policy to Brown, after which Brown sued Guarantee for bad faith in refusing to settle.<sup>119</sup> After the trial court sustained a demurrer by the defendant,<sup>120</sup>

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110. Accordingly, in an opinion ordered not published, a trial court was quoted as (and criticized for) referring to third-party-insurance bad-faith as “first party bad faith.” *Messersmith v. Mid-Century Ins. Co.*, 43 Cal. Rptr. 2d 871, 884 (Ct. App. 1995) (opinion ordered not published).

111. Third-party plaintiffs did enjoy a direct cause of action in California for almost ten years, beginning with the famous California Supreme Court case of *Royal Globe Insurance Co. v. Superior Court*, 592 P.2d 329 (Cal. 1979). This rule, which came from the era of Chief Justice Rose Bird, was overruled by the California Supreme Court in *Moradi-Shalal v. Fireman’s Fund Insurance Cos.*, 758 P.2d 58 (Cal. 1988). The author of an insurance-law treatise points out that the rule from *Royal Globe* “had virtually no following outside California.” JERRY, *supra* note 51, § 25, at 124.

112. See *Moradi-Shalal*, 758 P.2d at 61-68 (overruling *Royal Globe*, 592 P.2d at 329).

113. See Richmond, *An Overview*, *supra* note 94, at 88-89.

114. 319 P.2d 69 (Cal. Ct. App. 1957).

115. See *id.* at 70.

116. See *id.*

117. See *id.*

118. See *id.* at 71.

119. See *id.* at 70-71.

the appellate court reversed, holding that Guarantee could be found liable for damages resulting from its refusal to settle.<sup>121</sup> The court explained its reasoning as follows:

"It is the right of the insurer to exercise its own judgment upon the question of whether the claim should be settled or contested. But because it has taken over this duty . . . its exercise of this right should be accompanied by considerations of good faith."

...  
... Although the company, in dealing with the situation, has a right to consider its own interests, it has no right to sacrifice those of the insured.<sup>122</sup>

The 1958 case of *Comunale v. Traders & General Insurance Co.*<sup>123</sup> involved both a breach of the duty to settle and a breach of the duty to defend. Mr. and Mrs. Comunale sued a driver named Sloan who struck them while they were on foot.<sup>124</sup> Sloan had an insurance policy with a company called Traders with coverage limits of \$10,000 per individual and \$20,000 per accident.<sup>125</sup> Traders refused to defend Sloan, asserting that policy coverage did not apply because Sloan was driving another person's vehicle.<sup>126</sup> During the trial, the Comunales offered to settle for \$4000.<sup>127</sup> Sloan insisted that Traders was liable under the policy and urged the company to accept the settlement offer.<sup>128</sup> After Traders refused, a jury awarded damages of \$25,000 to Mr. Comunale and \$1250 to Mrs. Comunale.<sup>129</sup> Sloan did not pay, and the Comunales sued Traders under a provision of the policy authorizing an injured party to collect on judgments covered by the policy.<sup>130</sup> The court determined that coverage applied and awarded the policy limits to the Comunales.<sup>131</sup> Later, having obtained an assignment of rights from Sloan, the Comunales sued Traders again, this time for the damage award in excess

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120. See *id.* at 70.

121. See *id.* at 71.

122. *Id.* at 73-74 (quoting 40 A.L.R.2d 168, 171-72). Note that the *Brown* court declined to classify the claim as arising in tort or in contract, claiming any such effort "would be fruitless." *Id.* at 77.

123. 328 P.2d 198 (Cal. 1958).

124. See *id.* at 200.

125. See *id.*

126. See *id.*

127. See *id.*

128. See *id.*

129. See *id.*

130. See *id.*

131. See *id.*

of the policy limits.<sup>132</sup> The jury ruled in favor of the Comunales, but the trial judge entered a judgment for Traders notwithstanding the verdict.<sup>133</sup> In reversing the trial court, the California Supreme Court discussed the duty to settle and the duty to defend.

When there is great risk of a recovery beyond the policy limits so that the most reasonable manner of disposing [of] the claim is a settlement which can be made within those limits, a consideration in good faith of the insured's interest requires the insurer to settle the claim. Its unwarranted refusal to do so constitutes a breach of the implied covenant of good faith and fair dealing.

....  
... An insurer who denies coverage does so at its own risk, and, although its position may not have been entirely groundless, if the denial is found to be wrongful it is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach . . . .

At the end of the opinion in *Comunale*, the court specifically endorsed the view that the wrongful refusal to settle constitutes a tort.<sup>135</sup>

A recent and instructive case involving a breach of the duty to defend is *Amato v. Mercury Casualty Co.*<sup>136</sup> Mercury provided insurance coverage for a particular Renault automobile and various potential drivers.<sup>137</sup> Amato was a covered driver who drove the Renault negligently and thereby injured a passenger named Sutton.<sup>138</sup> When Sutton sued Amato, Mercury refused to defend, asserting that a policy exclusion precluded coverage for Sutton because she was a resident relative of the insured.<sup>139</sup> Lacking funds, Amato did not defend and Sutton was awarded a default judgment for \$167,750.<sup>140</sup> Sutton then sued Mercury, seeking payment on the judgment.<sup>141</sup> Amato also sued Mercury, alleging a breach of the covenant of good faith and fair dealing.<sup>142</sup> The trial court (*Amato I*) found that Sutton was in fact a resident relative and therefore ruled against Sutton.<sup>143</sup> At the same time, however, the court found that Mercury had in fact breached its duty to defend and ordered Mercury to pay Amato the full amount of the underlying judgment.<sup>144</sup> The holding was based on a finding that there was potential for coverage at the time Mercury refused to defend

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132. *See id.*

133. *See id.*

134. *Id.* at 201-02.

135. *See id.* at 203.

136. 61 Cal. Rptr. 2d 909 (Ct. App. 1997).

137. *See id.* at 911.

138. *See id.*

139. *See id.*

140. *See id.* at 912.

141. *See id.*

142. *See id.*

143. *See id.*

144. *See id.*



Amato.<sup>145</sup> The appellate court affirmed Mercury's liability, but held that damages should be limited to the costs of litigation.<sup>146</sup> On remand, the trial court (*Amato II*) determined that Amato incurred no litigation costs (due to his choice not to contest the charges) and therefore awarded judgment to Mercury.<sup>147</sup> In reviewing *Amato II*, the appellate court reversed again, this time holding that the trial court outcome in *Amato I* was the correct outcome after all.<sup>148</sup> The court justified its flip-flop by citing the "significant new case law" established after *Amato I*.<sup>149</sup> In holding Mercury liable for the full amount of the underlying judgment, the court wrote,

It may seem quixotic that Sutton is denied recovery on her direct action on the policy but Amato is entitled to recover for Mercury's failure to defend. However, the distinction is explainable by the difference in the nature of their respective claims. Sutton's claim depends on the contract terms of the coverage provisions of the insurance policy, whereas Amato's claim is based on the application of the judicially expanded duty to defend.<sup>150</sup>

A bad-faith breach of the duty to defend can also occur in the conflict-of-interest context discussed earlier in Part II.B.<sup>151</sup> A commentator explains,

Defense counsel's dual representation in third-party actions may spawn later first-party bad faith claims. . . . When a conflict of interest arises and defense counsel advances the insurer's interests to the insured's detriment, the insurer is guilty of . . . bad faith. . . .

The most common conflict of interest arises where an insurer defends under a reservation of rights. There always exists the possibility that a liability insurer that reserves its rights has a diminished interest in its insured's defense . . . . A conflict certainly arises . . . if counsel<sup>152</sup> hired by the insurer can control the outcome of attendant coverage issues.

We have seen third-party-insurance bad faith in connection with the duty to settle (*Brown*) and the duty to defend (*Comunale, Amato*). As mentioned earlier, third-party-insurance bad faith can also arise when an insurer breaches its duty to indemnify.<sup>153</sup> Insurer conduct constituting

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145. See *id.*

146. See *id.*

147. See *id.*

148. See *id.* at 913.

149. See *id.* at 915. The court was referring to *Montrose Chemical Corp. v. Superior Court*, 6 Cal. 4th 287 (1993), which was "decided shortly after *Amato I*." *Id.*

150. *Id.* at 918.

151. See Richmond, *An Overview*, *supra* note 94, at 112-13.

152. *Id.* at 112-13 (citations omitted).

153. See *id.* at 88.

such breach includes unreasonable delay,<sup>154</sup> failure to investigate,<sup>155</sup> or the attempting to compel an insured to contribute to settlement.<sup>156</sup> The breach of the duty to indemnify is discussed in further detail in the context of first-party-insurance bad faith below.

### 3. *First-Party-Insurance Bad Faith*

While third-party-insurance bad faith might involve the duty to settle, the duty to defend, or the duty to indemnify, first-party-insurance bad faith simply concerns the duty to indemnify.<sup>157</sup> However, as a commentator explains, this duty may be breached by a variety of insurer conduct, including “deceptive practices or deliberate misrepresentations to avoid paying claims, inadequate investigation, deliberate misinterpretation of records or policy language to avoid coverage, unreasonable litigation conduct, and unreasonable delay in resolving a claim.”<sup>158</sup>

The development of first-party-insurance bad faith claims trailed that of third-party-insurance bad faith,<sup>159</sup> and a minority of jurisdictions still does not recognize first-party-insurance bad faith.<sup>160</sup> In such minority jurisdictions, contract law provides any and all remedies for a breach of duty by the insurer.<sup>161</sup> The majority of jurisdictions, however, has deemed contract law inadequate, acknowledging first-party-insurance bad faith as an independent tort.<sup>162</sup> The Supreme Court of Nebraska has articulated a three-part rationale,<sup>163</sup> which might be rephrased as generally encompassing concerns about externalities, frustration of the contract purpose, and inequality of bargaining power.<sup>164</sup> First, externalities occur because the public has a distinct interest in the good-faith performance of insurers. The idea is that, when an insurer fails to so perform, society—not just the insured—suffers harm.<sup>165</sup> Second, because insurance contracts are highly technical, the protection bargained for by the consumer can be unfairly denied on the basis of an

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154. *See id.* at 99.

155. *See id.* at 101.

156. *See id.* at 103.

157. *See id.*

158. *Id.* at 111-12 (citations omitted).

159. *See id.* at 104.

160. *See* Douglas R. Richmond, *Insured's Bad Faith as Shield or Sword: Litigation Relief for Insurers?*, 77 MARQ. L. REV. 41, 49-50 (1993) [hereinafter Richmond, *Shield or Sword*].

161. *See id.* at 49.

162. *See id.* at 49-50.

163. *See* Braesch v. Union Ins. Co., 464 N.W.2d 769, 774-75 (Neb. 1991).

164. *See id.*

165. *See id.*

obscure technicality.<sup>166</sup> Finally, the insured is thought to deal from a position of weakness relative to the insurer, particularly when a significant loss occurs.<sup>167</sup>

A first-party-insurance bad faith cause of action was first embraced by the California Supreme Court in the 1973 case of *Gruenberg v. Aetna Insurance Co.*<sup>168</sup> Gruenberg was charged with arson in connection with fire damage at a restaurant he owned.<sup>169</sup> Gruenberg's insurer, Aetna, demanded that, in accordance with policy provisions, Gruenberg appear for an examination under oath.<sup>170</sup> Gruenberg's attorney sent a written response requesting that any examination be deferred until the criminal proceedings were completed.<sup>171</sup> Aetna refused the request, indicating that Gruenberg's failure to comply with Aetna's request would void the policy.<sup>172</sup> Several weeks later, the arson charge was dropped for lack of evidence.<sup>173</sup> Gruenberg's attorney then indicated that Gruenberg was available for examination, but Aetna replied that the policy had already become void.<sup>174</sup> Gruenberg sued Aetna, claiming that Aetna had conspired to deny Gruenberg his rightful coverage under the policy.<sup>175</sup> The trial court sustained Aetna's demurrer.<sup>176</sup> The California Supreme Court reversed the trial court's dismissal, holding that Gruenberg had stated a proper cause of action, notwithstanding Gruenberg's failure to strictly comply with the contractual provisions regarding Aetna's right of examination.<sup>177</sup> The court explained,

While it might be argued that defendants would be excused from their contractual duties (e.g., obligation to indemnify) if plaintiff breached his obligations under the policies, we do not think that plaintiff's alleged breach excuses defendants from their duty, implied by law, of good faith and fair dealing. In other words, the insurer's duty is unconditional and independent of the performance of plaintiff's contractual obligations.<sup>178</sup>

The court specifically held that a breach of the duty of good faith and

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166. *See id.*

167. *See id.*

168. 510 P.2d 1032 (Cal. 1973).

169. *See id.* at 1034.

170. *See id.*

171. *See id.* at 1034-35.

172. *See id.* at 1035.

173. *See id.*

174. *See id.*

175. *See id.*

176. *See id.* at 1035-36.

177. *See id.* at 1042.

178. *Id.* at 1040 (footnote omitted).

fair dealing in the context of first-party insurance creates a cause of action in tort.<sup>179</sup>

The 1992 case of *Mock v. Michigan Millers Mutual Insurance Co.*<sup>180</sup> dealt with an unreasonable delay of benefits. Mock was the owner of a \$1,500,000 home on the cliffs of Palos Verdes which he underinsured, the policy having a limit of \$139,500.<sup>181</sup> The homes in Mock's neighborhood suffered damages from earth movement caused by the City's negligent installation and maintenance of a storm drain.<sup>182</sup> While Mock's home itself showed only minimal physical damage, there was evidence that the home value had declined by roughly \$600,000 due to the pervasive effect of the City's error.<sup>183</sup> When the insurer stalled for no apparent reason, Mock sued.<sup>184</sup> Several months after the suit was filed, the insurer made payment of the policy limit but attempted to force Mock to assign to it "first-dollar" subrogation rights against the City.<sup>185</sup> The appellate court upheld a jury verdict finding that both the unreasonable delay and the attempt to force the assignment constituted breaches of the covenant of good faith and fair dealing.<sup>186</sup>

In the context of first-party insurance, the California courts have recited various limitations on bad-faith actions. Accordingly, "there are at least two separate requirements to establish breach of the implied covenant: (1) benefits due under the policy must have been withheld; and (2) the reason for withholding benefits must have been unreasonable or without proper cause."<sup>187</sup> As one commentator stated, "A reasonable insurer has a right to be wrong."<sup>188</sup> Likewise, an insurer may litigate an open legal question without incurring bad faith exposure.<sup>189</sup> Stated differently, "bad faith liability cannot be imposed where there 'exist[s] a genuine issue as to [the insurer's] liability under California law.'"<sup>190</sup> Finally, note that much of the law regarding first-party-insurance bad faith has been codified by statute in California.<sup>191</sup>

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179. *See id.* at 1037.

180. 5 Cal. Rptr. 2d 594 (Ct. App. 1992).

181. *See id.* at 597.

182. *See id.*

183. *See id.* at 598.

184. *See id.* at 600-01.

185. *See id.* at 602.

186. *See id.* at 615. In this case the jury awarded punitive damages of \$460,350, but the appellate court found error in the jury instructions concerning punitive damages and remanded for a new trial on damages only. *See id.*

187. *Love v. Fire Ins. Exch.*, 271 Cal. Rptr. 246, 255 (Ct. App. 1990).

188. *Richmond, An Overview*, *supra* note 94, at 109.

189. *See id.* at 110-11.

190. *Aceves v. Allstate Ins. Co.*, 827 F. Supp. 1473, 1484 (S.D. Cal. 1993) (quoting *Opsal v. United Servs. Auto. Ass'n*, 10 Cal. Rptr. 2d 352, 357 (1991) (review granted), citing *Safeco Ins. Co. v. Guyton*, 692 F.2d 551, 557 (9th Cir. 1982)).

191. *See* CAL. INS. CODE § 790.03 (West 1993).

#### 4. Remedies

Remedies for bad faith include the traditional contractual remedies and the extracontractual remedies reflecting the modern tort-characterization of bad-faith conduct.<sup>192</sup> Traditional contractual remedies consist primarily of expectations damages and economic losses, to the extent foreseeable.<sup>193</sup> Tort remedies for bad faith include both economic and non-economic damages (including emotional distress), and, under certain circumstances, punitive damages.<sup>194</sup> Section 3294 of the California Civil Code specifies the law regarding punitive damages and has been summarized by a California court as follows:

Evidence that an insurer has violated its duty of good faith and fair dealing does not thereby . . . justify an award of punitive damages. In order to establish that an insurer's conduct has gone sufficiently beyond mere bad faith to warrant a punitive award, it must be shown by *clear and convincing evidence* that the insurer has acted maliciously, oppressively or fraudulently.

The specific remedies available in any given case of bad faith depend on the type of duty breached (e.g., the duty to defend versus the duty to indemnify) and the severity of the breach (i.e., negligent breach, knowing breach, or MOF breach). Figure B, on page 826, classifies the types of bad faith (by the duty breached and the severity of the breach) and lists the corresponding remedies. As mentioned earlier, victims of insurer bad faith can obtain both contractual and extracontractual remedies, including, in some cases, punitive damages. When assessed, punitive damages can provide quite a wallop—sometimes in the hundreds of millions of dollars.<sup>196</sup> But, even in the absence of punitive damages, bad-faith insurers face other significant extracontractual penalties. An insurer, for example, that breaches its duty to defend must generally reimburse all defense costs in the suit, regardless of the potential for coverage, and forfeits any right for reimbursement of defense costs pertaining to non-covered claims.<sup>197</sup> Likewise, as in *Amato*, an insurer breaching its duty to defend can be held liable for the full amount of any judgment, up to the policy limits—even if it was

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192. See Sykes, *supra* note 99, at 408.

193. See *id.* at 408-09.

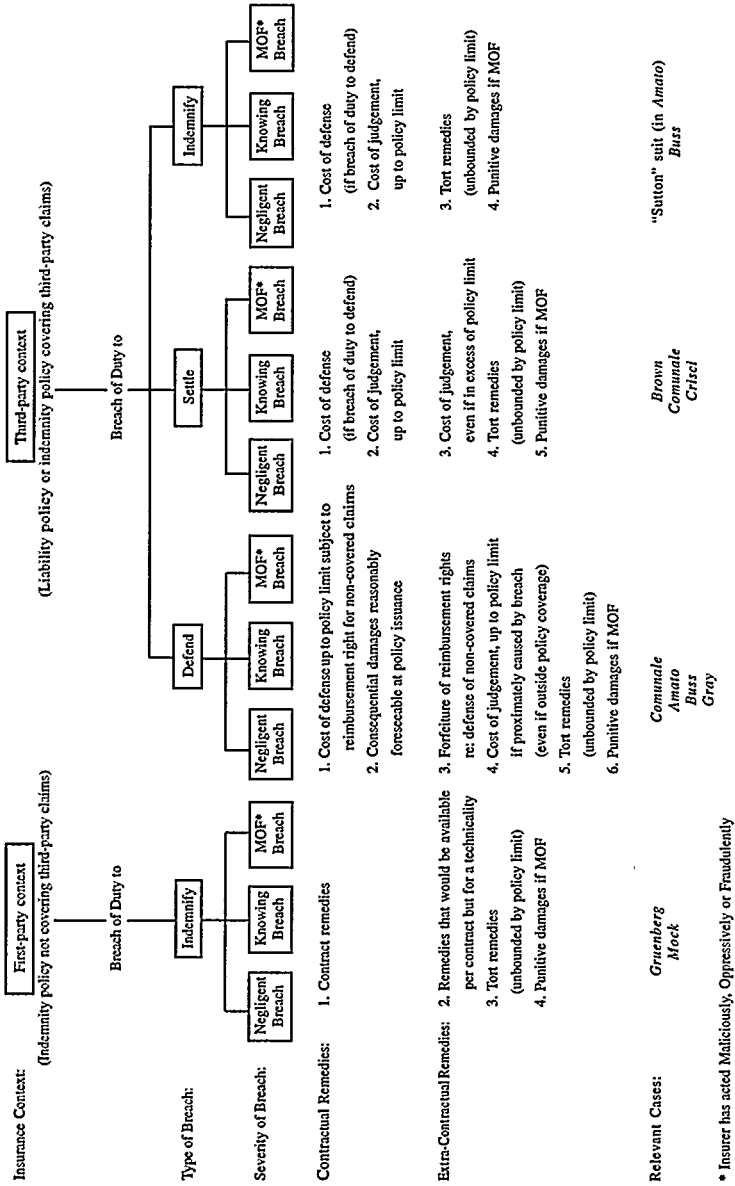
194. See Richmond, *An Overview*, *supra* note 94, at 79-80.

195. *Mock v. Michigan Millers Mut. Ins. Co.*, 5 Cal. Rptr. 2d 594, 607 (Ct. App. 1992) (citations omitted).

196. See Richmond, *An Overview*, *supra* note 94, at 75.

197. See *Buss v. Superior Court*, 939 P.2d 766, 779-80 (Cal. 1997).

FIGURE B  
REMEDIES FOR INSURER BAD FAITH IN CALIFORNIA



ultimately determined by the court that no indemnity coverage existed.<sup>198</sup> An insurer breaching its duty to settle faces even greater exposure, being liable for judgments even in excess of the policy limits.<sup>199</sup> Finally, the victim of insurer bad faith enjoys the full array of tort remedies (e.g., for emotional distress).<sup>200</sup> Collectively, these extracontractual remedies—both punitive and other—provide a powerful incentive for insurers to act properly toward insureds.

### 5. Comparative Bad Faith and Reverse Bad Faith

The duty of good faith and fair dealing applies to both the insurer and the insured.<sup>201</sup> This reciprocity forms the basis for the new concept of comparative bad faith, which was first explicitly discussed in California in the 1984 case of *Fleming v. Safeco Insurance Co.*<sup>202</sup> In *Fleming*, the insured sued the insurer for bad faith and prevailed. However, because the jury found some bad faith on the part of the insured, the court allowed the jury to offset from the award an amount corresponding to the harm caused by the insured's bad faith.<sup>203</sup> A year later, this concept received additional support in *California Casualty General Insurance Co. v. Superior Court*.<sup>204</sup> In that case, the defendant insurer was accused of bad faith and wished to amend its answer by alleging bad faith on the part of the insured. After the trial court denied the motion without stating reasons, the appellate court reversed, writing,

[W]e are persuaded that in an appropriate case, an insured's breach of the

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198. See *Amato v. Mercury Cas. Co.*, 61 Cal. Rptr. 2d 909, 914 (1997).

199. See discussion *supra* Part II.D.2.

200. See Richmond, *An Overview*, *supra* note 94, at 79-80.

201. See *Commercial Union Assurance Cos. v. Safeway Stores*, 610 P.2d 1038, 1041 (Cal. 1980).

202. 206 Cal. Rptr. 313 (Ct. App. 1984). The assertion that this case is the first to explicitly discuss comparative bad faith in California is found in *Kransco v. American Empire Surplus Lines Insurance Co.*, 63 Cal. Rptr. 2d 532, 548 (Ct. App. 1997) (Swager, J., dissenting) (review granted).

203. See *Fleming*, 206 Cal. Rptr. at 315. Note that the issue of comparative bad faith was not reviewed on appeal. Rather, the court wrote,

We note in passing that even comparing the bad faith of plaintiff with the bad faith of Safeco appears to have no precedent, but since that portion of the special verdict was utilized without any objection by either plaintiff or Safeco, and no issue was raised concerning it on this appeal, we need not determine its propriety.

*Id.* at 321.

204. 218 Cal. Rptr. 817 (Ct. App. 1985).

implied duty of good faith and fair dealing which contributes to an insurer's failure to pursue or delay in pursuing the investigation and payment of a claim may constitute at least a partial defense to the plaintiff's damage action for the insurer's breach of its duty of good faith and fair dealing . . . .

...  
... We perceive no sound reason . . . why the doctrine of comparative fault . . . should not be applicable to bad faith cases.<sup>205</sup>

Comparative fault in the context of bad faith surfaced again in the 1990 case of *Patrick v. Maryland Casualty Co.*<sup>206</sup> That case, however, did not involve any alleged bad faith on the part of the insured, and thus raised a different legal issue from that of *California Casualty*. In *Patrick*, the insured suffered property damage to his roof, for which he made a proper claim on his homeowner's policy.<sup>207</sup> Because the insurer did not pay promptly, the insured, a contractor by profession, resolved to do the repair himself.<sup>208</sup> While accomplishing the job, the insured fell from the roof and sustained serious bodily harm.<sup>209</sup> At trial, the insurer was not allowed to assert the defense that the insured's negligence contributed to the accident.<sup>210</sup> The appellate court reversed, however, holding that comparative fault is an appropriate defense—even when comparing the defendant's bad faith with the plaintiff's negligence.<sup>211</sup> The court rejected an "apples and oranges" objection, noting that comparative fault had been upheld where the comparison was between negligence and strict products liability.<sup>212</sup> The court further explained,

The most arresting feature which emerges from our review of the major comparative fault cases decided in the past 15 years is that, whenever the Supreme Court or the courts of appeal have been presented with a case affording an opportunity to expand the scope of comparative fault principles into new areas of tort law, the courts have done so.

This quotation from *Patrick* is no longer true, due to a divided California appellate court which wholly disapproved of the comparative bad faith defense in the 1997 case of *Kransco v. American Empire Surplus Lines Insurance Co.*<sup>214</sup> While the California Supreme Court has since granted review of this case to specifically evaluate the propriety of

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205. *Id.* at 822-23.

206. 267 Cal. Rptr. 24 (Ct. App. 1990) (certified for partial publication).

207. *See id.* at 26.

208. *See id.*

209. *See id.*

210. *See id.* at 27.

211. *See id.* at 28.

212. *See id.* at 29-30. By this way of reasoning, the comparative bad faith defense of *California Casualty* might be viewed as a species of comparative fault.

213. *Id.* at 30.

214. 63 Cal. Rptr. 2d 532 (Ct. App. 1997).



comparative bad faith,<sup>215</sup> the appellate court emphatically rejected the reasoning of *California Casualty*.<sup>216</sup> The appellate court began by noting the limited precedent on the subject, writing, "Judicial approval of the doctrine of comparative bad faith . . . rests exclusively upon intermediate appellate court decisions. Significantly, no state Supreme Court has embraced the doctrine, and the weight of authority is against it."<sup>217</sup> The court then went on to assert,

The California Casualty court's recognition of the . . . comparative bad faith defense does not survive close analysis . . . . [A]n insurer's breach of the covenant of good faith . . . is governed by tort principles . . . . An insured's breach of the covenant is not a tort. . . .

. . . This distinction between tort and contract convinced the Montana Supreme Court to reject comparative bad faith: "the [insurer's] tort cannot be offset comparatively by the [insureds'] contract breach."<sup>218</sup>

The majority went on to assert that, if the doctrine of comparative bad faith has any legitimacy, the defense must be strictly limited to cases where the insured's conduct directly contributed to the insurer's bad-faith conduct.<sup>219</sup>

After noting "a dearth of case law in California" concerning comparative bad faith,<sup>220</sup> the dissent in *Kransco* insisted that the doctrine is sound, arguing that,

[T]he contractual underpinnings of the duty of the insured . . . [are not] antithetical to apportionment of damages based upon comparative bad faith, as the majority opinion suggests. . . .

. . . Comparative bad faith merely allocates loss in proportion to fault; it does not deprive the insured of the benefit of the insurance bargain. . . . The insured does not insure against its own bad faith failure to abide by the terms of the insurance policy.<sup>221</sup>

While the status of comparative bad faith remains uncertain pending the California Supreme Court's review of *Kransco*, the related notion of "reverse bad faith" has not gained any support from the appellate courts

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215. See *Kransco v. American Empire Surplus Lines Ins. Co.*, 942 P.2d 414 (Cal. 1997). This is the citation to the California Supreme Court's granting of review.

216. See *Kransco*, 63 Cal. Rptr. 2d at 538. This is the appellate court case accepted for review by the California Supreme Court.

217. *Id.* at 538 n.1 (citations omitted).

218. *Id.* at 538-39 (citations omitted).

219. See *id.* at 542.

220. *Id.* at 548 (Swager, J., dissenting).

221. *Id.* at 550-51, 553 (Swager, J., dissenting).

in California.<sup>222</sup> The doctrine of reverse bad faith would give an insurer a direct cause of action against the insured for any bad faith on the part of the insured.<sup>223</sup> Accordingly, the insurer might utilize a “sword” akin to the “shield” of comparative bad faith.<sup>224</sup> While several commentators have strenuously urged the adoption of the reverse bad faith cause of action,<sup>225</sup> the courts remain steadfastly unpersuaded.<sup>226</sup> A commentator who favors a reverse bad faith remedy has summarized the reasons generally cited for the courts’ resistance:

[T]he reasons cited include: (1) “the insured, who often finds himself in dire financial straits after the loss, must have the equal footing which is provided by the ability to sue the insurer for bad faith;” (2) the insurer drafted the policy and can refuse the insured’s claim; (3) there are other avenues for the insurer to pursue in the event that an insured submits a fraudulent claim, including a cause of action against the insured for fraud; and (4) the insurer can have an adequate remedy against an insured who files a frivolous bad faith claim under a state rule of civil procedure allowing sanctions.<sup>227</sup>

### E. Contribution Law

Insurance companies may generally seek reimbursement from others for payments made pursuant to their policies under three circumstances.<sup>228</sup> The first form of reimbursement is called “equitable subrogation.”<sup>229</sup> This would occur in the first-party setting, for example, when a fire insurance company seeks reimbursement for a paid claim from a third-party tortfeasor (or insurer thereof) who caused the fire damage. The second form of reimbursement is called “equitable indemnity.”<sup>230</sup> This occurs in the third-party context when an insurer seeks reimbursement from a third-party (or insurer thereof) who is primarily liable for the loss.<sup>231</sup> The third form of reimbursement is called “equitable contribution,” or “contribution” for short.<sup>232</sup> An insurance

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222. See Schrenk & Palmquist, *supra* note 7, at 30.

223. See Richmond, *An Overview*, *supra* note 94, at 134.

224. See Richmond, *Shield or Sword*, *supra* note 160, at 41.

225. See Cathryn M. Little, *Fighting Fire with Fire: “Reverse Bad Faith” in First-Party Litigation Involving Arson and Insurance Fraud*, 19 CAMPBELL L. REV. 43, 66 (1996); Richmond, *An Overview*, *supra* note 94, at 139-40; Schrenk & Palmquist, *supra* note 7, at 30-31.

226. See Cathryn M. Little, *supra* note 225, at 46 (reporting that “the limited number of jurisdictions which have directly addressed the issue . . . have declined to recognize [a reverse-bad-faith cause of action]”).

227. *Id.* at 46-47 (citations omitted).

228. See CAL. PRAC. GUIDE INS. LIT. ch. 9, § B, at 9:7 (1998).

229. *Id.*

230. *Id.*

231. See *id.* ch. 9, § B, at 9:8.

232. *Id.* ch. 9, § B, at 9:11.

practice guide explains, "Where several insurers insure the same risk and each insurer is primarily liable for any loss, and one pays the entire loss, the action between them is one for equitable contribution."<sup>233</sup> The issues of this Comment concern this third area—equitable contribution.<sup>234</sup>

The doctrines of contribution and subrogation are often confused—even by the courts.<sup>235</sup> Understanding the difference between the two, however, can be critical. Consider, for example, the 1998 case of *Fireman's Fund Insurance Co. v. Maryland Casualty Co.*<sup>236</sup> In *Fireman's*, an insured was sued and tendered defense to two primary insurers, Fireman's and Maryland.<sup>237</sup> Fireman's agreed to defend under a reservation of rights, but Maryland refused to defend.<sup>238</sup> After this underlying case was settled, the insured sued Maryland for breach of contract and breach of the implied covenant of good faith and fair dealing.<sup>239</sup> In settling with the insured, Maryland obtained a release from any further claims regarding its failure to defend.<sup>240</sup> Fireman's, who did not join or intervene in the breach-of-duty case, then sued Maryland for equitable contribution.<sup>241</sup> Maryland defended by asserting that there could be no action for contribution given the release it obtained from the insured.<sup>242</sup> The appellate court held that "contribution and subrogation are entirely distinct and independent concepts,"<sup>243</sup> and affirmed the trial court's finding that Fireman's had a right of contribution against Maryland.<sup>244</sup> The court's careful elucidation of the doctrines of subrogation and contribution is cited below.

The court explained subrogation, as follows:

Subrogation is defined as the substitution of another person in place of the creditor or claimant to whose rights he or she succeeds in relation to the debt or claim. By undertaking to indemnify or pay the principal debtor's obligation to

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233. *Id.*

234. For purposes of this Comment, we will assume that the payers and non-payers insure *exactly* the same risks. Accordingly, the payer's action is one for equitable contribution.

235. See *Fireman's Fund Ins. Co. v. Maryland Cas. Co.*, 77 Cal. Rptr. 2d 296, 308 n.7 (Ct. App. 1998); CAL. PRAC. GUIDE INS. LIT., *supra* note 228, ch. 9, § B, at 9:15.

236. 77 Cal. Rptr. 2d 296 (Ct. App. 1998).

237. See *id.* at 299-300.

238. See *id.* at 300.

239. See *id.*

240. See *id.*

241. See *id.*

242. See *id.*

243. *Id.* at 299.

244. See *id.* at 309.

the creditor or claimant, the “subrogee” is equitably *subrogated* to the claimant (or “subrogor”), and succeeds to the subrogor’s rights against the obligor. In the case of insurance, subrogation takes the form of an insurer’s right to be put in the position of the insured in order to pursue recovery from third parties legally responsible to the insured for a loss which the insurer has both insured and paid. . . .

....  
The right of subrogation is purely derivative. . . . The subrogated insurer is said to “stand in the shoes” of its insured . . . .<sup>245</sup>

The court then discussed contribution.

Equitable contribution is entirely different. It is the right to recover, not from the party *primarily* liable for the loss, but from a *co-obligor* who *shares* such liability with the party seeking contribution. In the insurance context, the right to contribution arises when several insurers are obligated to indemnify or defend the same loss or claim, and one insurer has paid more than its share of the loss or defended the action without any participation by the others. Where multiple insurance carriers insure the same insured and cover the same risk, each insurer has independent standing to assert a cause of action against its coinsurers for equitable contribution when it has undertaken the defense or indemnification of the common insured. Equitable contribution permits reimbursement to the insurer that paid on the loss for the excess it paid over its proportionate share of the obligation, on the theory that the debt it paid was *equally* and *concurrently* owed by the other insurers and should be shared by them *pro rata* in proportion to their respective coverage of the risk. The purpose of this rule of equity is to accomplish substantial justice by equalizing the common burden shared by coinsurers, and to prevent one insurer from profiting at the expense of others.<sup>246</sup>

The court made several further observations: (1) Because equitable contribution presumes multiple insurers providing equal coverage, there is generally no contribution right as between a primary insurer and an excess insurer.<sup>247</sup> (2) An insurer asserting a contribution action does not “stand in the shoes of the insured”—that is, it does not derive its claim from any existing claim of the insured.<sup>248</sup> (3) An insured who obtains coverage from multiple insurers does not thereby gain a right to compensation in excess of damages actually suffered.<sup>249</sup> Thus, if one such insurer fully compensates the insured for a loss, the insured has no claim (other than a possible bad-faith claim) against other non-paying insurers for the same loss.<sup>250</sup> By the same token, these non-paying insurers have no liability to the insured who has been fully compensated, but may be held liable in a contribution suit brought by the paying

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245. *Id.* at 302-03 (citations omitted).

246. *Id.* at 303-04 (footnote omitted) (citations omitted).

247. *See id.* at 304 n.4. Issues peculiar to actions between primary and secondary insurers fall outside the scope of this Comment.

248. *See id.* at 304.

249. *See id.* at 305.

250. *See id.*

insurer.<sup>251</sup> (4) Subrogation, and not contribution, is the appropriate cause of action by a paying insurer against a non-paying insurer when the two policies cover different risks.<sup>252</sup> (5) Finally, the public policy served by the doctrine of contribution differs from that served by subrogation.<sup>253</sup> The court explains,

The aim of equitable subrogation is to place the burden for a loss on the party ultimately liable or responsible for it and by whom it should have been discharged, and to relieve entirely the insurer or surety who indemnified the loss and who in equity was *not* primarily liable therefor. On the other hand, the aim of equitable contribution is to apportion a loss between two or more insurers who cover the same risk, so that each pays its fair share and one does not profit at the expense of the others.<sup>254</sup>

Two final notes on contribution: First, when a court determines that contribution is appropriate, it must then specify an appropriate allocation<sup>255</sup>—often a pro rata formulation reflecting the respective coverage limits of the relevant policies.<sup>256</sup> Second, equitable contribution did not exist under the common law.<sup>257</sup>

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251. *See id.*

252. *See id.* at 307. Accordingly, subrogation law is not applicable to the issues herein. The discussion of subrogation has been included merely to clarify the law concerning contribution.

253. *See id.* at 305-06.

254. *Id.* (citations omitted). In reviewing this Comment, Professor Wonnell at the University of San Diego Law School offered an alternative rationale for the law of contribution, which rationale he found not compelling. The idea is that contribution law provides a default rule to which insurance companies would agree *a priori* in order to reduce risk. This theory suffers from two deficiencies. First, as Wonnell pointed out, insurers are generally considered to be risk neutral entities, and therefore would lack any incentive (absent a diversification problem) to reduce risk. Second, this theory seems to complicate matters unduly. Contribution law need not involve any implied agreement to minimize risk. Rather, contribution law simply constitutes a particular application of the familiar equitable doctrine of unjust enrichment. Essentially, the payer is saying to the non-payer, "I paid both my debt *and* your debt; you therefore owe me for your share of the obligation so discharged."

255. *See, e.g.,* CNA Cas. v. Seaboard Sur. Co., 222 Cal. Rptr. 276, 288 (Ct. App. 1986).

256. Consideration of alternative allocation methods falls beyond the scope of this Comment.

257. *See* 5 WITKIN, SUMMARY OF CALIFORNIA LAW 9TH Torts, § 82, at 157 (9th ed. 1988). The contemporary law of contribution in California reflects judicial interpretations of statutes. For a list of applicable statutes, see the CALIFORNIA PRAC. GUIDE INS. LIT., *supra* note 228, ch. 9, § B, at 9:13.

## F. The Insurer's Predicament

When an insured tenders defense of a third-party suit to its insurer and the insurer believes that there is no duty to defend based on a lack of coverage, the insurer faces a delicate situation. As one commentator has written,

In these cases, the stakes are high . . . . An erroneous decision on either side of this issue can result in large and unwarranted expense for an insurer, either in the form of damages paid in an action premised upon a wrongful refusal to defend, or in the payment of attorneys' fees in a case for which there was no potential indemnity under the policy.<sup>258</sup>

Justice Arabian of the California Supreme Court has recognized that the issue of the duty to defend can dwarf the issue of indemnification.

It is beyond serious dispute that once the duty to defend attaches, the insurer often finds it necessary to fund all or part of a settlement regardless of its underlying duty to indemnify, because the costs of defense may far exceed the settlement offer.<sup>259</sup> The duty to defend becomes, in effect, the duty to indemnify.

As a legal text states, "Manifestly . . . the decision whether to defend . . . is frequently difficult for the insurer."<sup>260</sup> The insurer faces a predicament.

A liability insurer can respond to this predicament in various ways.<sup>261</sup> First, it can defend without any reservation of rights.<sup>262</sup> Second, it can defend under a reservation of rights.<sup>263</sup> Third, possibly in connection with a reservation of rights, it can seek a judicial determination that no defense is owed.<sup>264</sup> Fourth, it can simply deny coverage, based only on its own determination of non-coverage.<sup>265</sup> These alternatives are further discussed below.

Even though an insurer suspects that there is no duty to defend, it might nonetheless elect to defend without any reservation of rights. The reason is two-fold. First, such a course virtually eliminates any bad-faith exposure. Second, absent a reservation of rights and assuming no

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258. King & Benas, *supra* note 71, at 269.

259. Horace Mann Ins. Co. v. Barbara B., 846 P.2d 792, 804 (Cal. 1993) (Arabian, J., dissenting).

260. 39 CAL. JUR. 3D *Insurance Contracts* § 564, at 362 (1996).

261. I have slightly modified the assessment of one commentator who writes that "[t]he insurer may: 1) defend without any reservation of rights; 2) defend under a reservation of rights; or 3) disclaim coverage." Sue C. Jacobs, *The Duty to Defend*, 557 PLI LITIG. & ADMIN. PRAC. COURSE HANDBOOK SERIES 7, 11-12 (1997).

262. *See id.* at 11-12.

263. *See id.*

264. *See* Montrose Chem. Corp. v. Superior Court, 861 P.2d 1153, 1161 (Cal. 1993).

265. *See* Jacobs, *supra* note 261, at 11-12.

impermissible conflict of interest, the insurer avoids the *Cumis* rule and thereby retains full management control over the litigation and/or settlement process. This control can be a powerful incentive for the insurer,<sup>266</sup> but it comes at a price. When the insurer defends without any reservation of rights, waiver and/or estoppel doctrines may preclude reimbursement of the insurer by the insured for non-covered disbursements.<sup>267</sup>

The second alternative overcomes the waiver and estoppel concerns. A legal text explains,

[W]here the insurer is doubtful about its liability and wishes to retain all its rights and at the same time protect itself against the claim that it has unjustifiably refused to defend a suit against the insured, it may defend the case under a so-called nonwaiver agreement, or reservation of rights, by which it reserves all its rights to assert later the policy breach or noncoverage.<sup>268</sup>

A reservation of rights, however, has its drawbacks. First, in order to be effective, a reservation of rights must be timely,<sup>269</sup> and it must specifically enumerate the grounds for non-liability.<sup>270</sup> Accordingly, an insurer may be estopped from asserting certain defenses not included in the reservation of rights.<sup>271</sup> Second, as alluded to above, the potential requirement of providing *Cumis* counsel constitutes a significant disadvantage to defending under a reservation of rights.<sup>272</sup> Third, an insurer gains no benefit from the reservation of rights unless and until it demonstrates non-coverage.<sup>273</sup> Notwithstanding these drawbacks the insurer can sometimes derive a huge benefit by defending under a reservation of rights.<sup>274</sup>

266. See Susan Randall, *Redefining the Insurer's Duty to Defend*, 2 CONN. INS. L.J. 221, 261 (1997).

267. An insurer that defends without any reservation of rights is deemed to have waived its right to contest coverage. See *Truck Ins. Exch. v. Superior Court*, 59 Cal. Rptr. 2d 529, 533 (Ct. App. 1996). Similarly, insurers have been estopped to assert defenses not specifically mentioned in a reservation of rights. See Jacobs, *supra* note 261, at 50.

268. 39 CAL. JUR. 3D *Insurance Contracts* § 564, at 362 (1996).

269. See Jacobs, *supra* note 261, at 38.

270. See *id.* at 37.

271. See *id.* at 53.

272. See Randall, *supra* note 266, at 261.

273. See *Johansen v. California State Auto. Ass'n Inter-Ins. Bureau*, 538 P.2d 744, 750 (Cal. 1975).

274. Consider the recent case of *Buss v. Superior Court*, 939 P.2d 766 (Cal. 1997). Buss, the prominent owner of professional sports teams and a major sports arena, unilaterally terminated a contract with an entity called H&H Sports. See *id.* at 769. H&H sued Buss, alleging 27 counts. See *id.* Buss tendered defense of the suit to its

Whether the insurer defends under a reservation of rights or denies coverage, the third alternative—seeking a judicial determination—may be prudent.<sup>275</sup> Accordingly, the California Supreme Court stated, “In order to avoid any possibility that a refusal to defend may subject it to eventual liability for bad faith, the insurer is well advised to seek a judicial determination that it owes no defense. This it may [secure within] a declaratory relief action.”<sup>276</sup> This approach, however, has its own drawbacks. First, pursuing declaratory relief means more litigation expense—in particular because summary judgment will not be granted in a declaratory relief action whenever the policy language is ambiguous or the facts relevant to coverage are disputed.<sup>277</sup> Second, the seeking of declaratory relief may itself be offered as evidence of bad faith when there is no reasonable basis for disputing coverage.<sup>278</sup> Finally, any declaratory relief action will normally be stayed when it involves issues to be addressed in the underlying third-party suit.<sup>279</sup> The California Supreme Court explained, “To eliminate the risk of inconsistent factual determinations that could prejudice the insured, a stay of the declaratory relief action pending resolution of the third party suit is appropriate when the coverage question turns on facts to be litigated in the underlying action.”<sup>280</sup>

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insurer, Transamerica. *See id.* Because only one claim—that for defamation—of the 27 counts alleged showed any potential for coverage, Transamerica agreed to defend under a reservation of rights, also agreeing to afford *Cumis* counsel. *See id.* at 770. By the time the suit settled, Transamerica had paid over \$1,000,000 in defense costs, with only some small portion (apparently in the range of \$20,000 to \$60,000) pertaining to the covered defamation claim. *See id.* Transamerica subsequently brought suit seeking a declaration that it had a right of reimbursement for defense costs not allocable to the covered defamation claim. *See id.* at 771. The trial court denied a motion by Buss for summary judgment, and this ruling was affirmed by the appellate court. *See id.* The California Supreme Court granted review and held that Transamerica could claim reimbursement for defense costs by demonstrating by a preponderance of the facts that such costs “can be allocated solely to the claims that are not even potentially covered.” *Id.* at 778. Finding sufficient facts to suggest that Transamerica might meet this burden, the Supreme Court affirmed the lower court rulings denying summary judgment for Buss, thereby affording potential reimbursement of approximately \$950,000. *See id.* at 784.

275. *See Montrose Chem. Corp. v. Superior Court*, 861 P.2d 1153, 1161 (Cal. 1993).

276. *Id.*

277. *See Save Mart Supermarkets v. Underwriters at Lloyd’s London*, 843 F. Supp. 597, 604 (N.D. Cal. 1994) (finding that an “employee exception” clause was ambiguous and therefore holding that summary judgment was not appropriate).

278. *See Dalrymple v. United Servs. Auto. Ass’n*, 46 Cal. Rptr. 2d 845, 854 (Ct. App. 1995) (“It is at least arguable that pursuing a declaratory relief action regarding coverage could be done for reasons indicating bad faith may be present: e.g., if there were no proper cause to dispute coverage, and if more than an erroneous interpretation of a policy . . . were concerned.”).

279. *See Montrose*, 861 P.2d at 1162.

280. *Id.* The court further explained,



As a final alternative, the insurer can deny coverage based solely on its own assessment of non-coverage.<sup>281</sup> While such a course can be very risky, a recent California case confirms that it is not inherently wrongful.<sup>282</sup> The court explained,

[A]ppellants contend that [the insurer] owed [the insured] a duty to defend because it failed to obtain a declaratory judgment concerning its duty to defend when the defense was tendered. This is incorrect. When, as here, there is no potential for coverage on the basis of the facts known to the insurer at the time of tender and the insurer "has made an informed decision on the basis of the third party complaint and the extrinsic facts known to it at the time of tender that there is no potential for coverage, the insurer may refuse to defend the lawsuit."<sup>283</sup>

### III. ISSUES AND ARGUMENTS

Moving now to the post-Alliance contribution action at issue herein, the non-payer has faced the predicament described and has responded by electing our fourth alternative—it denied coverage, relying solely on its own assessment of non-coverage due to *collusive fraud*.<sup>284</sup> This being so, we are now ready to consider whether (and under what circumstances) such non-payer can be held liable for contribution to the payer.<sup>285</sup> A simple and accurate answer might be that the non-payer

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For example, when the third party seeks damages on account of the insured's negligence, and the insurer seeks to avoid providing a defense by arguing that its insured harmed the third party by intentional conduct, the potential that the insurer's proof will prejudice its insured in the underlying litigation is obvious. This is the classic situation in which the declaratory relief action should be stayed. By contrast, when the coverage question is logically unrelated to the issues of consequence in the underlying case, the declaratory relief action may properly proceed to judgment. An illustration of this latter sort of case is found in *Flynt*. There, the question whether the owner had granted permission for the driver's use of the car was irrelevant to the third party's personal injury claim, and could properly be determined in the declaratory relief action independently of the timing of the third party suit.

*Id.* (citation omitted).

281. See *Zelda, Inc. v. Northland Ins. Co.*, 66 Cal. Rptr. 2d 356, 365 (Ct. App. 1997).

282. See *id.*

283. *Id.* (quoting *Gunderson v. Fire Ins. Exch.*, 44 Cal. Rptr. 2d 272, 277 (Ct. App. 1995)).

284. Recall that, by definition, collusive fraud involves wrongful (indeed criminal) conduct by the insured. The alleged involvement of a guilty insured is a critical and limiting assumption of this Comment.

285. Recall that, by assumption, the payer and the non-payer have equivalent policies that insure exactly the same risks.

should be made to contribute if the insurers (payer and non-payer) shared a duty to defend in the first place. But notice that this answer may not be very helpful. Conceptually, the trier of fact in the contribution action must evaluate the likely verdict of a hypothetical trier of fact. That is, if the payer, instead of assuming the insured's defense in the underlying suit, had instead denied coverage on the grounds of collusive fraud—how would this hypothetical trier of fact rule? If the hypothetical trier of fact would have found collusive fraud, there would be no duty to defend, nor any duty of the non-payer to contribute later. If, on the other hand, the hypothetical trier of fact would not have found collusive fraud, the payer would have had a duty to defend, and the non-payer would later be liable for contribution. However, precisely because the collusive fraud issue was not litigated prior to the non-payer's decision to deny coverage, the issue becomes thorny. Can we merely assume that, because one insurer stepped up and assumed the defense, the non-payer must have had a duty to defend? If not, who has the burden of proof in the contribution action? And, what is the burden of proof?

The following analysis begins with a highly theoretical question and then proceeds to more practical questions. The theoretical question asks, "Does or should an insurer have a duty to defend when he 'knows' that the insured is involved in a collusive fraud?" Then, a more practical question asks, "When there is 'substantial' evidence of collusive fraud, does or should an insurer have the discretion to refuse to defend?" Next, this Comment considers whether the payer might be said to owe certain "gatekeeper" duties to the non-payer. Finally, this Comment considers the ultimate burden-of-proof issues—i.e., in the contribution action, who must prove what?

*A. Does or Should an Insurer Have a Duty to Defend when It "Knows" that the Insured Is Involved in Collusive Fraud?*

*1. Payer Arguments*

*a. Precedent Establishes that There Is a Duty to Defend when the Complaint on Its Face Indicates There Could Be Coverage—Even Where the Insurer Knows the Claim Is Not Covered*

This argument states what has been called the "complaint rule."<sup>286</sup> A

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286. Randall, *supra* note 266, at 222.

commentator explains,

In virtually every jurisdiction, the allegations of the complaint against a liability insured determine an insurer's defense obligation. The virtues of the rule are simplicity and protection of insureds' interests in receiving a defense: the complaint provides an easy way to assess an insurer's obligation, particularly where coverage is questionable and may depend on the resolution of the litigation against an insured. If the complaint alleges a covered claim, the insurer must defend.<sup>287</sup>

The complaint rule finds support in many jurisdictions. Accordingly, New York's highest court noted approvingly in a 1991 case that "the courts of this State have refused to permit insurers to look beyond the complaint's allegations to avoid their obligation to defend."<sup>288</sup> Similarly, a federal court applying Pennsylvania law in 1995 cited the complaint rule, noting that "[u]nder Pennsylvania law, an insurance company is obligated to defend an insured whenever the complaint filed by the injured party may *potentially* come within the policy's coverage. The obligation to defend is determined solely by the allegations of the complaint in the action."<sup>289</sup>

The California courts, until very recently, also espoused the complaint rule. Thus, an appellate court wrote in 1986,

Indeed, the duty to defend is so broad that as long as the complaint contains language creating the potential of liability under an insurance policy, the insurer must defend an action against its insured even though it has independent knowledge of facts not in the pleadings that establish that the claim is *not* covered.<sup>290</sup>

However, the complaint rule was dealt a fatal blow in the California Supreme Court's 1993 decision in *Montrose Chemical Co. v. Superior Court*.<sup>291</sup> After noting a conflict of opinions among the appellate courts on the subject, the court held that, "where extrinsic evidence establishes that the ultimate question of coverage can be determined as a matter of law on undisputed facts, we see no reason to prevent an insurer from seeking summary adjudication that no potential for liability exists and thus that it has no duty to defend."<sup>292</sup> Two years later, the California Supreme Court confirmed this rule, saying that, "where the extrinsic

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287. *Id.*

288. *Fitzpatrick v. American Honda Motor Co.*, 575 N.E.2d 90, 92 (N.Y. 1991).

289. *Kiewit E. Co. v. L&R Constr. Co.*, 44 F.3d 1194, 1205 (3d Cir. 1995).

290. *CNA Cas. v. Seaboard Sur. Co.*, 222 Cal. Rptr. 276, 279 (Ct. App. 1986).

291. 861 P.2d 1153, 1159-60 (Cal. 1993).

292. *Id.* at 1159.

facts eliminate the potential for coverage, the insurer may decline to defend even when the bare allegations in the complaint suggest potential liability.”<sup>293</sup> For better or for worse, the complaint rule has been rejected in California.

*b. Fraud Is Not a Recognized Exception to the Duty to Defend*

In one sense, this argument is beyond dispute. The California Supreme Court, as recently as 1995, has written that the duty to defend “applies even to claims that are ‘groundless, false, or fraudulent.’”<sup>294</sup> On the other hand, the argument clearly claims too much. First, there can be no coverage of any fraudulent claim if the same claim, made truthfully, would not be covered.<sup>295</sup> Such non-coverage can be established by the insurance contract itself—either in the main text of the insuring agreement or in the exclusions.<sup>296</sup> For example, a Louisiana court in 1992 held that an insurer had no duty to defend an insured being sued for sexual molestation because an exclusion stated that the insurer “shall have no duty to defend any claim . . . involving sexual molestation . . . regardless of the circumstances . . . even though the allegations may be groundless, false, or fraudulent.”<sup>297</sup>

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293. *Waller v. Truck Ins. Exch.*, 900 P.2d 619, 628 (Cal. 1995).

294. *Id.* at 627 (quoting *Gray v. Zurich Ins. Co.*, 419 P.2d 168, 173 (Cal. 1966)). The reason for this rule is obvious. Guarding against the exposure of an innocent person to the risk of groundless, false, or fraudulent third-party claims constitutes a major purpose of virtually all liability insurance.

295. *See Horace Mann Ins. Co. v. Barbara B.*, 846 P.2d 792, 801 n.1 (Cal. 1993) (Baxter, J., concurring) (“[T]he duty to defend groundless claims only applies when the claims, if *not* groundless, might be covered.”); JERRY, *supra* note 51, § 111, at 730 (“[A] general rule might be stated as follows: The insurer has a duty to defend any lawsuit alleging claims against its insured for which, if liability were later established, the insurer would be required to pay damages on behalf of the insured.”).

296. *See Waller*, 900 P.2d at 625.

297. *Duplantis v. State Farm Gen. Ins. Co.*, 606 So. 2d 51, 52-53 (La. Ct. App. 1992) (emphasis added).

Second, the non-payer would point out the crucial difference between a fraud on the insured and a fraud on the insurer.<sup>298</sup> The latter, herein termed “collusive fraud,” is not a covered risk. Consider, for example, the 1997 California case of *Andrade v. Jennings*.<sup>299</sup> Andrade, while working for his employer, Jorge, aboard a commercial fishing boat, suffered a slip-and-fall accident allegedly caused by Jorge’s negligence.<sup>300</sup> Jennings provided excess liability insurance to cover losses exceeding the primary policy limit of one million dollars.<sup>301</sup> Because the primary insurer had become insolvent,<sup>302</sup> Jorge (and the boat lienholder) colluded with Andrade, attempting to shift the loss onto Jennings.<sup>303</sup> Accordingly, Jorge and Andrade executed a settlement agreement for roughly \$1,500,000<sup>304</sup> (on an injury actually worth no more than \$250,000<sup>305</sup>), Andrade agreed not to execute against Jorge’s

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298. Figure C, *infra* page 842, shows the types of insurance fraud possible in the third-party setting and demonstrates the critical distinction between fraud on the insurer and fraud on the insured. This Comment addresses only collusive fraud, defined to include only fraud involving collusion by the insured. See *supra* note 4. Consider for the moment, however, the half of the diagram labeled “Fraud on the Insured.” Three types of cases can be distinguished. (1) The first involves the simple (and undoubtedly common) fraud on the insured perpetrated by the third-party plaintiff. An example would be a claim for injuries not actually suffered. Because protection from such claims is a primary purpose of insurance, insurers defend such claims routinely. (2) The second involves a fraud perpetrated by the insured’s counsel without the knowledge of the insured. An example is intentional overbilling. If counsel is not *Cumis* counsel, the solution to the problem is relatively straightforward—the insurer must attempt to hire honest counsel for its insured, and then must supervise and monitor effectively. The more difficult scenario involves an innocent insured represented by fraudulent *Cumis* counsel. Nevertheless, it seems apparent that the problem, difficult as it may be, belongs to the insurer and cannot be passed on to the innocent insured. There is simply no basis for absolving the insurer of its contractual duty to defend its innocent and good-faith insured. The insurer must defend its insured and, at the same time, somehow find a way to minimize such exposure. Just how to do this is an interesting question, but one which lies beyond the scope of this Comment. (3) The third type of fraud on the insured involves both the third-party plaintiff and the insured’s counsel. The sum of comments concerning the first two types of fraud on the insured would apply equally to this third type.

299. 62 Cal. Rptr. 2d 787 (Ct. App. 1997).

300. See *id.* at 790.

301. See *id.* at 789.

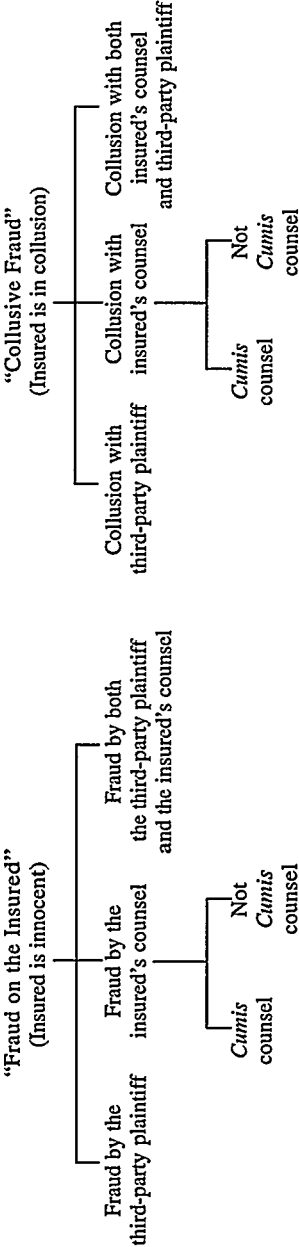
302. See *id.*

303. See *id.* at 797-98. Note that such collusion by the insured (Jorge) and the third-party plaintiff (Andrade) constitutes a *fraud on the insurer*, rather than a *fraud on the insured*.

304. See *id.* at 793-94.

305. See *id.* at 795.

FIGURE C  
INSURANCE FRAUD IN THE THIRD-PARTY SETTING



estate,<sup>306</sup> and Jorge assigned his rights against Jennings to Andrade.<sup>307</sup> Meanwhile, because attorneys involved deliberately kept Jennings uninformed or misinformed, Jennings did not attend the prove-up hearing in federal court.<sup>308</sup> After approval of the stipulated judgment, when Andrade sued Jennings in a California court to collect the judgment, Jennings defended on the basis that the judgment was the product of collusion.<sup>309</sup> The trial court awarded summary judgment to Andrade, but the appellate court reversed.<sup>310</sup> Ultimately, a jury delivered a verdict in favor of Jennings,<sup>311</sup> which verdict was upheld on appeal.<sup>312</sup> The appellate court explained,

Jennings may raise the defense of collusion against Andrade because “[a]s against the injured person an insurer may assert a defense based on breach by the insured of the cooperation clause of the policy.’ Collusive assistance in the procurement of a judgment not only constitutes a breach of the cooperation clause but also is a breach of the covenant of good faith and fair dealing.”

As the insured, Jorge owed its excess insurer Jennings the duty of good faith and fair dealing.<sup>313</sup> An insured may not manipulate claims to an excess carrier’s detriment.

While *Andrade* concerned indemnity only, by analogy such a manipulation of claims cannot create a duty to defend.

*c. Notwithstanding the Known Existence of Collusive Fraud, the Law Should Require the Liability Insurer to Provide a Defense of the Insured—This in Order to Avoid Creating the Potential for Abuse by Other Insurers*

In *Gray v. Zurich Insurance Co.*,<sup>314</sup> the insurer (who was found to have wrongfully denied its duty to defend) argued that it should be liable only for the cost of the defense and not for payment of the damage award.<sup>315</sup> While the facts of the case suggest that the insurer might not have had a contractual duty to indemnify the insured, the California Supreme Court nonetheless rejected the insurer’s argument, reasoning in part that the

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306. *See id.* at 789.

307. *See id.*

308. *See id.* at 791-94.

309. *See id.* at 794.

310. *See id.*

311. *See id.* at 795.

312. *See id.* at 802.

313. *Id.* at 798 (citations omitted).

314. 419 P.2d 168 (Cal. 1966).

315. *See id.* at 178-79.

rule proposed would “encourage insurance companies to similar disavowals of responsibility with everything to gain and nothing to lose.”<sup>316</sup> The above payer’s argument suggests a similar fear. The fear, common in the law, is that, once insurers realize that they might avoid defending an insured by pleading collusive fraud, insurers will make such pleadings without justification and will sometimes prevail. Or, worse still, irresponsible insurers might collude with their own insureds to deny coverage to a third-party victim.<sup>317</sup>

In rebuttal, the non-payer can point out that severe penalties are inflicted on an insurer found to act in bad faith. Allowing an insurer to decline defense coverage when it has knowledge of collusive fraud does not in any way lessen the enormous and effective incentives prevailing today for an insurer to act in good faith. Moreover, are we really comfortable denying justice to an insurer victimized by a criminal conspiracy? Admittedly, a bright-line rule achieves some judicial economy. Admittedly, also, the sophisticated and devastating collusive fraud perpetrated by the Alliance may not be very common. But denying the courts an ability to administer justice on a case-by-case basis seems to offend the basic values of the American system of justice. Indeed, the California Supreme Court has resisted compromise of a similar nature, writing,

Indubitably juries and trial courts, constantly called upon to distinguish the frivolous from the substantial and the fraudulent from the meritorious, reach some erroneous results. But such fallibility, inherent in the judicial process, offers no reason for substituting for the case-by-case resolution of [cases] an artificial and indefensible barrier. Courts not only compromise their basic responsibility to decide the merits of each case individually but destroy the public’s confidence in them by using the broad broom of “administrative convenience” to sweep away a class of claims a number of which are admittedly meritorious.<sup>318</sup>

## 2. *Non-Payer Arguments*

### *a. Collusive Fraud Is a Breach of the Cooperation Clause Which Eliminates Any Duty to Defend*

The requirement of cooperation by the insured has been termed a “condition precedent” to an insurer’s duty of indemnification.<sup>319</sup> The insured’s duty to cooperate with its liability insurer has been

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316. *Id.* at 179.

317. This concern was expressed by the dissent in *Valladao v. Fireman’s Fund Indemnity Co.*, 89 P.2d 643, 651 (Cal. 1939) (Houser, J., dissenting).

318. *Dillon v. Legg*, 441 P.2d 912, 918 (Cal. 1968).

319. *Valladao*, 89 P.2d at 650 (quoting *Finkle v. Western Auto. Ins. Co.*, 26 S.W.2d 843, 847 (Mo. Ct. App. 1930)).



characterized as “the flipside of the insurer’s duty to defend.”<sup>320</sup> Surely an insured who commits a collusive fraud, either by collusion with the third-party plaintiff or the insured’s fraudulent attorney, violates this requirement.<sup>321</sup> As explained in a legal text, such a violation relieves the insurer of any duty to defend.

An insurer is not bound to continue to defend an action against an insured who substantially breaches the conditions of the policy with respect to such matters as prompt notice of an accident or suit and cooperation in the defense, resulting in prejudice to the insurer. If the insurer shows such a breach, it may deny coverage during the pendency of the underlying action and cease to defend the action . . . .<sup>322</sup>

Concealment or misrepresentation violates the non-cooperation clause and therefore eliminates any duty to defend.<sup>323</sup>

*b. Collusive Fraud Constitutes a Material Misrepresentation Which Eliminates Any Duty to Defend*

Insurance policies generally contain language similar to the following:

This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein,<sup>324</sup> or in case of any fraud or false swearing by the insured relating thereto.

The voiding of a policy on the basis of misrepresentation derives from contract law.<sup>325</sup> Note that even an incomplete disclosure, if material, can void the policy.<sup>326</sup> Moreover, courts have held that this provision will be

320. JERRY, *supra* note 51, § 110, at 719.

321. Robert H. Jerry explains, “Indeed, a principle purpose of the cooperation clause is the prevention of collusion between the insured and the injured third party.” *Id.* at 720. “Collusion . . . is perhaps the worst kind of noncooperation.” *Id.* at 728.

322. 39 CAL. JUR. 3D *Insurance Contracts* § 561, at 355 (1996).

323. *See id.* § 565, at 366.

324. Little, *supra* note 225, at 66 n.72.

325. Robert H. Jerry explains,

The misrepresentation defense in insurance law is simply a variant of the more general contract law principle that allows an injured party to void a contract when that party’s assent to the bargain is induced by the fraudulent or material misrepresentation of the other contracting party, and the injured party relies on the misrepresentation in question.

JERRY, *supra* note 51, § 102(a), at 682 (citation omitted).

326. *See* Joseph K. Powers, *Pulling the Plug on Fidelity, Crime, and All Risk Coverage: The Availability of Rescission as a Remedy or Defense*, 32 TORT & INS. L.J.

assumed even in the absence of explicit language.<sup>327</sup> As a California court recently stated, a finding that “the underlying action is a sham . . . obviate[s] the necessity of further defense.”<sup>328</sup>

*c. Collusive Fraud Is a Breach of the Implied Covenant of Good Faith and Fair Dealing and Eliminates Any Duty to Defend*

A California appellate court recognized that collusion by the insured against the interest of the insurer “not only constitutes a breach of the cooperation clause but also is a breach of the covenant of good faith and fair dealing.”<sup>329</sup> Collusive fraud therefore constitutes a defense to coverage.<sup>330</sup>

*d. In the Context of Collusive Fraud, There Is No “Accident,” and the Insurer Therefore Has No Duty to Defend*

Liability insurance policies are meant to protect the insured against the unforeseen—with a typical policy limiting coverage to injuries caused by “an accident . . . which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.”<sup>331</sup> An example of such a limitation of coverage can be seen in the 1986 case of *Royal Globe Insurance Co. v. Whitaker*.<sup>332</sup> In this case, Knighten, the insured, was a homebuilder who contracted to build and sell a home to Whitaker with the close of escrow to be no later than a specified date.<sup>333</sup> When escrow closed late, Whitaker sued Knighten for breach of contract and for fraud, alleging that Knighten had never in fact intended to deliver by the specified date.<sup>334</sup> After Knighten’s insurer, Royal Globe, refused to defend, the parties entered into a stipulated judgment for Whitaker.<sup>335</sup> In return for a covenant not to execute, Knighten then assigned his rights against Royal Globe to Whitaker.<sup>336</sup> When Royal Globe sought a declaratory judgment that it had no duty to defend or

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905, 910 (1997) (citing *Methodist Med. Ctr. v. American Med. Sec.*, 38 F.3d 316, 319-20 (7th Cir. 1994); *Mutual Benefit Life Ins. Co. v. Lindenman*, 911 F. Supp. 619, 624-25 (E.D.N.Y. 1995); *Erie Ins. Exch. v. Lane*, 227 A.2d 231 (Md. 1967)).

327. *See id.* at 924 (citing as example *Bird v. Penn Cent. Co.*, 334 F. Supp. 255, 258 (E.D. Pa. 1971)).

328. *Horace Mann Ins. Co. v. Barbara B.*, 846 P.2d 792, 799 (Cal. 1993).

329. *Span, Inc. v. Associated Int’l Ins. Co.*, 277 Cal. Rptr. 828, 839 (Ct. App. 1991).

330. *See Andrade v. Jennings*, 62 Cal. Rptr. 2d 787, 798 (Ct. App. 1997).

331. *Royal Globe Ins. Co. v. Whitaker*, 226 Cal. Rptr. 435, 435 (Ct. App. 1986) (alteration in original) (citations omitted).

332. 226 Cal. Rptr. 435 (Ct. App. 1986).

333. *See id.* at 435.

334. *See id.* at 435-36.

335. *See id.* at 436.

336. *See id.*

indemnify, Whitaker filed a cross complaint against Royal Globe.<sup>337</sup> The trial court ruled for Royal Globe, finding that the insured could have no reasonable expectation of coverage based on language in the policy limiting coverage to accidents.<sup>338</sup> The appellate court affirmed, noting that “[a]n intentional act is not an ‘accident’ within the plain meaning of the word.”<sup>339</sup> In essence, because fraud is always an intentional act, such alleged conduct lies outside the limits of “accident” coverage and thus there was no duty to defend. The non-payer would therefore argue: If the insured’s conduct is *actually* fraudulent (as against the insurer) rather than merely *allegedly* fraudulent (as against the third-party), the insured’s claim must be even weaker than the claim of Knighten in *Whitaker*, and therefore must be rejected.

*e. Collusive Fraud on the Insurer Constitutes a Willful Act of the Insured Which, by Statute, Precludes Insurance Coverage*

A federal district court in California explained,

Regardless of the express language of a policy, California Insurance Code § 533 establishes an implied exclusionary clause which must be read into every insurance agreement. Section 533 provides that “[a]n insurer is not liable for a loss caused by the willful act of the insured . . . [.]”<sup>340</sup>

Consider the application of this statute in the 1993 case of *Aetna Casualty & Surety Co. v. Sheft*.<sup>341</sup> In that case, Sheft sued the estate of his former lover Rock Hudson (the movie star) for damages caused because Hudson had AIDS and misrepresented and concealed this fact while continuing in a sexual relationship with Sheft.<sup>342</sup> When Hudson’s estate tendered defense to Aetna (Hudson’s insurer), Aetna disclaimed coverage based on both the policy exclusion for intentional acts and section 533.<sup>343</sup> The trial court ruled for Aetna, finding coverage precluded on both grounds.<sup>344</sup> The appellate court affirmed, but qualified its opinion in a footnote, saying,

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337. *See id.*

338. *See id.*

339. *Id.* at 437-38 (citation omitted).

340. *Save Mart Supermarkets v. Underwriters at Lloyd’s London*, 843 F. Supp. 597, 605 (N.D. Cal. 1994) (first alteration in original) (citation omitted).

341. 989 F.2d 1105 (9th Cir. 1993).

342. *See id.* at 1106.

343. *See id.*

344. *See id.*

[B]ecause the parties do not distinguish between an insurer's duty to defend and its duty to indemnify, we do not consider the possibility that the district court may have erred in holding that Aetna had no duty to defend even, while the court correctly concluded that the insurer owed no duty to indemnify.<sup>345</sup>

In fact, California courts have split on the issue avoided by the appellate court in *Aetna*.<sup>346</sup> Some courts assert that "a contract to defend an assured upon mere accusations of a wil[l]ful tort does not encourage such wil[l]ful conduct" and therefore is not void under section 533.<sup>347</sup> Other courts have found no duty to defend in the context of alleged willful conduct.<sup>348</sup> A commentator notes,

The cases of *Republic Indemnity Co. v. Superior Court* and *Ohio Casualty Insurance Co. v. Hubbard* are frequently cited for the proposition that Insurance Code § 533 will only preclude an indemnity obligation and have no effect on the duty to defend analysis. The [case of *B & E Convalescent Center v. State Compensation Insurance Fund*<sup>349</sup>] is significant in that it arises out of the same district as both *Republic Indemnity* and *Ohio Casualty*. The *B & E Convalescent Center* case has made it clear that a defense is required, where coverage is otherwise precluded by Insurance Code § 533, only where the insurance policy language itself creates a reasonable expectation that the policy will afford a defense. Where the policy itself does not create any such expectation, Insurance Code § 533 may appropriately preclude defense as well as indemnity.<sup>350</sup>

Based upon the reasoning of *B & E Convalescent Center v. State Compensation Insurance Fund*,<sup>351</sup> an insurer owes no duty to defend to an insured perpetrating collusive fraud. Section 533 precludes such coverage and the insured certainly cannot be heard to say that the policy creates an expectation of coverage for such a claim.

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345. *Id.* at 1109 n.3 (citation omitted).

346. See 39 CAL. JUR. 3D *Insurance Contracts* § 557, at 344-47 (1996).

347. *CNA Cas. v. Seaboard Sur. Co.*, 222 Cal. Rptr. 276, 285 n.8 (Ct. App. 1986) (citing *Gray v. Zurich Ins. Co.*, 419 P.2d 168, 177 (Cal. 1966)).

348. See, e.g., *B&E Convalescent Ctr. v. State Compensation Ins. Fund*, 9 Cal. Rptr. 2d 894 (Ct. App. 1992).

349. 9 Cal. Rptr. 2d 894 (Ct. App. 1992)..

350. *King & Benas*, *supra* note 71, at 261 (citations omitted).

351. 9 Cal. Rptr. 2d 894 (Ct. App. 1992).

*B. Assuming There Is "Substantial" But Inconclusive Evidence of Collusive Fraud, Does an Insurer Who Refuses to Defend Thereby Commit a Breach of Duty?*

*1. Payer Arguments*

*a. When a Liability Insurer Suspects Collusive Fraud, It Must Nonetheless Defend the Insured Until Such Suspicion Becomes an Irrefutable Fact*

The California courts have held that "[a]ny doubt as to whether the facts give rise to a duty to defend is resolved in the insured's favor."<sup>352</sup> In 1993, the California Supreme Court reinforced this rule, saying, "Facts merely tending to show that the claim is not covered, or may not be covered, but are insufficient to eliminate the possibility . . . of coverage . . . add no weight to the scales."<sup>353</sup> Likewise, a 1996 California appellate court wrote, "Once a prima facie showing is made that the underlying action fell within coverage provisions, an insurer may defeat a motion for summary judgment only by producing undisputed extrinsic evidence conclusively eliminating the potential for coverage under the policy."<sup>354</sup> A 1995 Georgia case further illustrates, in the indemnity context, that the insurer carries a heavy burden. In *Georgia Farm Bureau Mutual Insurance Co. v. Richardson*,<sup>355</sup> a fire insurer denied coverage to the insured whose house burned down when it discovered evidence suggesting arson.<sup>356</sup> The appellate court upheld a jury verdict for the insured, including damages for bad faith by the insurer, finding that "there was absolutely no proof that [the insured] actually set the fire."<sup>357</sup> In a similar vein, the payer would argue that a liability insurer

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352. *Horace Mann Ins. Co. v. Barbara B.*, 846 P.2d 792, 796 (Cal. 1993) (citation omitted).

353. *Montrose Chem. Corp. v. Superior Court*, 861 P.2d 1153, 1161 (Cal. 1993).

354. *Maryland Cas. Co. v. National Am. Ins. Co.*, 56 Cal. Rptr. 2d 498, 504 (Ct. App. 1996) (citation omitted).

355. 457 S.E.2d 181 (Ga. Ct. App. 1995).

356. *See id.* at 186. The evidence showed that the fire had been accelerated by a flammable liquid, the insured had been experiencing financial difficulties, the insured had given some conflicting statements regarding her finances, a neighbor had not seen the insured at her home in the days before the fire, and that the insured and her family were not staying at the house on the night of the fire. *See id.*

357. *Id.*

must defend unless and until it can disprove any and all potential for coverage.

The non-payer's rebuttal of this argument is discussed below in Part III.B.2.a.

*b. Because an Allegation of Collusive Fraud Can Only Be Conclusively Resolved by Trial, the Insurer May Not Unilaterally Decide to Withhold a Defense on a Claim Which, if Not Fraudulent, Would Be Covered*

Payer might assert that any alleged misbehavior by the insured, even if true, does not relieve the insurer of its duty to defend. Payer would cite language from *Gruenberg v. Aetna Insurance Co.*<sup>358</sup> (discussed earlier in connection with first-party bad faith): “[T]he insurer’s duty is unconditional and independent of the performance of [the insured’s] contractual obligations.”<sup>359</sup> Accordingly, payer would argue, the insurer must either defend or obtain declaratory relief. Payer would also cite *CNA Casualty v. Seaboard Surety Co.*,<sup>360</sup> which states that an issue concerning material concealment “is a question of fact to be decided by the trial court on the basis of the evidence.”<sup>361</sup> By analogy, the payer would argue, any unproven allegation of collusion should be resolved through the judicial process—not by the insurer in a unilateral manner.

The non-payer would attempt to rebut this argument by first noting that the *Gruenberg* quote refers to the duty of good faith and fair dealing—not the duty to defend.<sup>362</sup> Because not every refusal to defend constitutes a breach of the duty of good faith and fair dealing, this rule does not help much. Second, the non-payer would assert that the law does allow the insurer to make determinations of its own concerning coverage, albeit at its own risk. Accordingly, the *Comunale* court wrote,

An insurer who denies coverage does so at its own risk, and, although its position may not have been entirely groundless, if the denial is found to be wrongful it is liable for the full amount which will compensate the insured for all the detriment caused by the insurer’s breach of the express and implied obligations of the contract.<sup>363</sup>

Therefore, when there are some grounds for denial, the insurer has the discretion to deny coverage, with penalties accruing if the denial is found to be wrongful. The non-payer would argue that, by implication,

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358. 510 P.2d 1032 (Cal. 1973).

359. *Id.* at 1040.

360. 222 Cal. Rptr. 276 (Ct. App. 1986).

361. *Id.* at 286.

362. *See Gruenberg*, 510 P.2d at 1040.

363. *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 202 (Cal. 1958).

the denial is at least potentially not wrongful, and thus the payer's argument fails. Finally, the non-payer would argue that there is a good public-policy reason for allowing the insurer the unilateral discretion to deny coverage. As the New Jersey Supreme Court wrote,

[T]he insured urges the carrier should be required to seek a declaration of its duty before the trial of the injured party's suit against the insured. But that proposition could lead to unnecessary litigation, for it would compel a lawsuit whenever coverage is denied even though the insured may silently agree with the carrier's position. We think the better course is to leave it to the contenders to decide for themselves if and when to sue.<sup>364</sup>

## 2. Non-Payer Arguments

### a. *The Law Affords Insurers the Discretion to Deny Coverage in the Face of Uncertainty when Done Within the Bounds of Reason and Good Faith*

The non-payer would point to the words of a 1995 California Supreme Court decision concerning the duty to defend: "[Precedent] does not hold, as plaintiffs suggest, that the insurer must always defend a third party lawsuit . . . 'until the extent of 'the policy coverage' is legally certain' . . . . This has never been the law."<sup>365</sup> Thus, the non-payer would argue that, in the context of substantial evidence of collusive fraud, there is no such rigid rule demanding the insurer to defend. A 1996 California appellate court recognized that a purportedly absolute duty to defend must yield to reason, writing that "the insurer has no duty to defend where the potential for liability is 'tenuous and farfetched.'"<sup>366</sup> Also, because collusive fraud voids the policy entirely, a good-faith denial of coverage for reasonable cause cannot be wrongful for the simple reason that a "bad faith claim cannot be maintained unless policy benefits are due."<sup>367</sup>

Precedent supports reasonable and good-faith denials of coverage, at least in the context of indemnification. Compare the result in the

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364. *Burd v. Sussex Mut. Ins. Co.*, 267 A.2d 7, 11 (N.J. 1970).

365. *Waller v. Truck Ins. Exch.*, 900 P.2d 619, 632 (Cal. 1995) (citations omitted).

366. *Michaelian v. State Compensation Ins. Fund*, 58 Cal. Rptr. 2d 133, 141 (Ct. App. 1996) (citing *American Guar. & Liability v. Vista Med. Supply*, 699 F. Supp. 787, 794 (N.D. Cal. 1988)).

367. *Waller*, 900 P.2d at 622.

*Richardson* case cited above with the 1995 case of *Allstate Insurance Co. v. Madan*.<sup>368</sup> In *Madan*, the court found that a fire insurer who denied coverage based on evidence of arson was not guilty of bad faith, notwithstanding inconclusive evidence.<sup>369</sup> The court explained that “[a] court can conclude as a matter of law that an insurer’s denial of a claim is not unreasonable, so long as there existed a genuine issue as to the insurer’s liability.”<sup>370</sup> The non-payer would argue that, by analogy, a liability insurer need not defend when there is substantial evidence of collusion by the insured.

*b. When There Is Substantial Evidence of Collusion, the Interests of Public Policy Are Best Served by Allowing the Insurer the Discretion to Deny Coverage*

In the actual post-Alliance contribution case, the non-payer argued that the payer caved in to extortion-like pressures from the Alliance. According to the non-payer, the payer defended because it feared a bad-faith suit, rather than because it owed any duty under the policy.<sup>371</sup> Essentially, the payer “wimped out,” having been intimidated by a bully, the Alliance. Such conduct, the non-payer would assert, constitutes a woeful abdication of responsibility—working to the considerable detriment of society at large. According to the non-payer, every insurance company can and should serve a screening function by vigorously opposing collusive fraud.

Moreover, the non-payer would argue that allowing the insurer the ability to perform such a screening function does not diminish the strong incentives, currently in place, which encourage good faith performance by insurers. As one commentator writes,

[A]n insurer has strong incentives to undertake the defense of an insured where it appears that there is coverage, based on the facts. The insurer’s duty to defend is a right as well as a duty: the insurer’s ability to participate in and control a lawsuit protects the insurer’s interests in containing defense costs and minimizing its liability exposure. If there is coverage, or it appears likely that there is coverage, the insurer will want to defend to protect its interests.<sup>372</sup>

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368. 889 F. Supp. 374 (C.D. Cal. 1995).

369. *See id.* at 380.

370. *Id.*

371. *See* Interview with Robert K. Schraner, *supra* note 26.

372. Randall, *supra* note 266, at 261 (citation omitted). Robert H. Jerry concurs, writing,

Although no known source of data allows these observations to be tested empirically, it would seem that most insurers provide a defense whenever it appears that coverage is possible; this is because insurers want to control the defense and reduce their own (and their insured’s) indemnity exposure if



As discussed earlier, the prospect of punitive damages looms like a giant hammer over the head of the insurer. Thus, if the insurer denies coverage in bad faith—e.g., it denies on the basis of collusion without having a reasonable and good-faith belief that such collusion exists—enormous damages can be assessed.

The non-payer would also argue that stripping insurers of the ability to independently resist collusive fraud will enhance the potential for extortion. Consider in this regard the writing of California Supreme Court Justice Baxter in 1993.

As the majority suggest[s], the insurer is free to use the litigation process to winnow sham claims . . . . However, it is well to remember that from the insurer's perspective, the duty to defend, with its attendant costs, imposes the pressure to settle.

. . . . However groundless [a claim] might ultimately prove, it can supply invaluable leverage toward a compromised recovery from the insurer's funds.<sup>373</sup>

Finally, the non-payer would point out that forcing the insurer to go to court for declaratory relief adds more burden to a heavily strained legal system.

*C. In Connection with a Contribution Action, Are There Any  
"Gatekeeper" Duties Owed by the Payer to the  
Non-Payer Which Must Be Satisfied?*<sup>374</sup>

*1. Non-Payer Argument*

*a. Prior to Any Award of Contribution to the Payer, the Payer Must  
Demonstrate that It Managed the Defense of the Insured in  
Good Faith and in a Reasonable Manner*

The universal interest of insurers in cost containment, particularly in the face of increasing fraud, has led to highly structured efforts to

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possible. By this same analysis, it would seem that insurers are likely to deny a defense only when they, rightly or wrongly, are very certain that the claim is outside coverage.

JERRY, *supra* note 51, § 111, at 743.

373. Horace Mann Ins. Co. v. Barbara B., 846 P.2d 792, 801 (Cal. 1993) (Baxter, J., concurring).

374. The notion that there might be such a duty was suggested to this author during the Interview with Robert K. Schraner, *supra* note 26.

control “outside” legal costs. A commentator explains, “Most insurers now require defense counsel to adhere to reporting and billing requirements set forth in outside counsel guidelines. Under such guidelines, insurers refuse to pay counsel for certain tasks undertaken or expenses incurred in the defense of insureds.”<sup>375</sup> The question arises whether a payer should be similarly held to reasonable standards regarding the management of an insured’s defense. Assuming contribution is appropriate, could the non-payer nonetheless assert a cross-complaint against the payer for negligent mismanagement of the case? For example, if the non-payer can show that a reasonable insurer would have detected collusive fraud but the payer defended nonetheless, could the non-payer, if compelled to contribute, subsequently sue the payer to recover its portion of the expenditures? A 1986 annotation in the *American Law Reports* (ALR) discussed a similar question—“whether an excess insurer may maintain a *direct* action against a primary insurer for that insurer’s improper or inadequate defense of claim.”<sup>376</sup> The ALR author found one case on point, the 1984 New York case of *Hartford Accident & Indemnity Co. v. Michigan Mutual Insurance Co.*<sup>377</sup> In that case, the primary insurer (Michigan) and the excess insurer (Hartford) both insured three related companies.<sup>378</sup> When Michigan defended a negligence suit against two of the three insured companies, Hartford demanded that Michigan implead the third insured company.<sup>379</sup> Michigan refused, allegedly in order to shift exposure from Michigan to Hartford.<sup>380</sup> After the case settled for \$1,400,000, and Hartford paid \$400,000 of the award, Hartford sued Michigan for, inter alia, bad faith in failing to implead the third insured.<sup>381</sup> The trial court granted Michigan’s motion for summary judgment, but the appellate court reversed and New York’s highest court granted review.<sup>382</sup> The high court recognized a direct cause of action against the primary

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375. Douglas R. Richmond, *The Business and Ethics of Liability Insurer’s Efforts to Manage Legal Care*, 28 U. MEM. L. REV. 57, 59 (1997).

376. Jane M. Draper, Annotation, *Liability Insurance: Excess Carrier’s Right of Action Against Primary Carrier for Improper or Inadequate Defense of Claim*, 49 A.L.R.4th 304, 305 (1986) (emphasis added) (citations omitted). Note that the claim under consideration in this ALR annotation is a *direct* claim. Accordingly, the claim is distinct from a claim by an excess insurer against a primary insurer alleging a wrongful refusal to settle within the primary coverage limit. In this latter type of case, the action is not a direct claim; instead it is “based on the theory of equitable subrogation.” *Commercial Union Assurance Cos. v. Safeway Stores*, 610 P.2d 1038, 1041 (Cal. 1980).

377. 463 N.E.2d 608 (N.Y. 1984).

378. *See id.* at 609.

379. *See id.*

380. *See id.* at 609-10.

381. *See id.* at 610.

382. *See id.*

insurer, writing,

Michigan Mutual as the primary liability insurer owed to Hartford as the excess carrier the same duty to act in good faith which Michigan owed to its own insureds . . . . Whether Michigan Mutual acted . . . in its own interest so as to activate Hartford's excess liability without having to share in . . . [that liability is] a question to be determined upon trial . . . .<sup>383</sup>

Arguing by analogy, the non-payer would assert that the payer has a comparable duty to the non-payer. Arguably, this duty would continue beyond the initial decision to defend, such that defending beyond the point when a reasonable insurer would terminate the defense (e.g., based on evidence of a collusive fraud) would constitute a breach of such duty.

The payer would attempt to rebut this argument in five ways. First, the New York precedent is not binding on California courts. Second, the cited case involves the interplay of primary and excess insurance—a wholly different context from a contribution action. Third, the facts are otherwise distinguishable: Michigan gained an unwarranted benefit directly at the expense of Hartford. In the Alliance context, by contrast, the payer's conduct was not self-serving and indeed hurt the payer as much as it hurt anyone else. Fourth, the courts should proceed with great caution and reluctance to find a duty where none has previously been recognized. Indeed the courts have consistently emphasized the propriety of such restraint in a series of modern cases concerning insider trading. In *Chiarella v. United States*,<sup>384</sup> for example, after an employee at a printing press was convicted for trading on information he gleaned from documents concerning a pending takeover attempt, the United States Supreme Court reversed, finding that the lower courts had “failed to identify a relationship between [the employee/stock buyer] and [his stock trading partners] that could give rise to a duty.”<sup>385</sup> Later, in *United States v. Chestman*,<sup>386</sup> after a stock broker had been convicted under Rule 10(b)(5) for insider trading, a United States appellate court reversed that conviction, stating that “a fiduciary duty cannot be imposed unilaterally by entrusting a person with confidential information.”<sup>387</sup> By similar reasoning, the payer would argue that there is no duty, contractual or otherwise, owed by the payer to the non-payer, and the payer's decision

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383. *Id.*

384. 445 U.S. 222 (1980).

385. *Id.* at 232.

386. 947 F.2d 551 (2d Cir. 1991).

387. *Id.* at 567.

to defend cannot unilaterally create such a duty. Finally, the payer would argue that recognizing such a duty serves no public policy purpose because in a contribution action the plaintiff can claim only reasonable expenses anyway.<sup>388</sup>

*D. Given that the Non-Payer Denied Coverage on the Basis of Collusive Fraud, What Must Be Proven in a Subsequent Contribution Action?*

*1. Payer Arguments*

- a. Where the Payer Lacked Conclusive Knowledge of a Collusive Fraud at the Time the Defense Was Tendered, the Courts Should Enforce a Bright-Line Rule Mandating Contribution by the Non-Payer in Order to Achieve Judicial Economy, Avoid a Potential Free-Rider Problem, and Spread Losses*

The courts frequently employ convenient shortcuts for allocating liability in an inexact but acceptable manner. An example is the “time on the risk” method of apportionment used in the context of continuous injury cases. A commentator explains, “In the settlement of continuous injury cases, where the causation of injuries cannot be placed in definite policy periods, the ‘time on the risk’ method seems to be the tool of choice for apportioning responsibility . . . .”<sup>389</sup> In discussing the application of such an approach to a particular case, the commentator wrote, “The analysis used by the court . . . is logical and realistic. The court concluded that even though it would have been scientifically possible to prove the amount of harm occurring during each policy period, it was nonetheless far too expensive to warrant such proof in that case.”<sup>390</sup> For the same reason, the payer would argue, trying to adjudicate the duty to defend years after the fact would be very expensive. For this reason, the more realistic approach would be to simply mandate contribution.

The payer would also argue that a bright-line rule additionally serves

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388. See *Travelers Ins. Co. v. Industrial Indem. Co.*, 96 Cal. Rptr. 191, 193 (Ct. App. 1971) (where “reasonableness of attorneys’ fees and costs were resolved” by stipulation).

389. Rob S. Register, Comment, *Apportioning Coverage Responsibility of Consecutive Insurers when the Actual Occurrence of Injury Cannot Be Ascertained: Who Has to Contribute in a Settlement?*, 49 MERCER L. REV. 1151, 1159 (1998).

390. *Id.* at 1160.

to eliminate a potential free-rider problem. The concern is that, absent a sure contribution requirement, insurer *A* might improperly deny its duty to defend—in the hope that insurer *B* will provide the defense and will either not pursue contribution or will somehow fail to prevail in a contribution action. In other words, if there are legal arguments available to get *A* off the hook, *A* might prefer to roll the dice and see what happens. Clearly, such an incentive operates to the detriment of the entire insurance system.

Lastly, the payer might assert that there is a public policy benefit from spreading the loss among insurers through mandatory contribution. By spreading losses, insurers would presumably avoid catastrophic losses, this having a stabilizing and otherwise beneficial effect on the insurance system generally.

The non-payer would counter with three arguments. First, bright-line rules often frustrate the administration of justice. As a California appellate court wrote in connection with community-property law,

We recognize that were we to adopt an inflexible rule, it might help litigating spouses and their counsel settle . . . disputes and, at the same time, provide an easy measure to be applied by trial courts. However, to do so would be to follow the recent tendency of appellate courts and the Legislature, which we decry, to adopt rules which on the surface are easy to apply and foster consistency yet, as applied, too often achieve inequitable results.

Accordingly, a California appellate court in 1995 rejected fast-track justice, writing, “A nonparty insurer must be given a fair opportunity to litigate the question of whether [a] settlement was unreasonable or was the product of fraud or collusion . . . .”<sup>392</sup>

Second, the non-payer would take a different view regarding incentives. As discussed above, powerful incentives are currently in place to discourage such free-riding, and these incentives remain intact regardless of the rule applicable in a contribution action. Accordingly, any insurer who wrongfully refuses coverage may be subject to costly extra-contractual damages, including punitive damages. Moreover, denying the non-payer any ability to contest coverage could itself create undesirable incentives. For example, any one insurer would have less incentive to fight collusive fraud, knowing that it can pass the buck if and when it confronts the problem. Or, worse still, a fraudulent insurer in conspiracy with a fraudulent insured might intentionally defend a

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391. *In re Marriage of Hug*, 201 Cal. Rptr. 676, 686 (Ct. App. 1984).

392. *Pruyn v. Agricultural Ins. Co.*, 42 Cal. Rptr. 2d 295, 311 (Ct. App. 1995).

frivolous claim, with the purpose of forcing contribution from the innocent insurer who is outside the conspiracy. Effectively, the dollars so “spent” would be transferred figuratively from the left hand to the right, augmented by considerable funds from the honest co-insurer. In short, the proposed bright-line rule could be a cure worse than the disease.

Finally, the non-payer would object to the idea that mandatory contribution supports a worthy goal of loss spreading. Insurance companies are perfectly capable of accomplishing risk management through reinsurance without the help of a paternalistic judicial system. Moreover, in the words of a California appellate court, “It is not the role of the courts to legislate.”<sup>393</sup> Absent an established basis in the law, the courts should let the loss lie where it falls.

*b. Because the Non-Payer Refused to Join the Payers in Managing the Insured’s Defense, the Non-Payer Is Estopped from Asserting Fault in the Defense Afforded*<sup>394</sup>

The payer would argue that the non-payer is estopped from denying coverage (or otherwise criticizing the manner of defense afforded) by virtue of its failure either to obtain declaratory relief up front or to defend under a reservation of rights. This argument finds some support in the 1995 decision of an Illinois appellate court, which wrote,

Under Illinois law, when a liability insurer questions whether the insured’s claim might possibly fall within the scope of the policy coverage, the insurer must either (1) seek a declaratory judgment as to its rights and obligations before or pending trial or (2) defend the insured under a reservation of rights. When an insured tenders defense to an insurer, the insurer may not simply refuse to participate in the litigation and wait for the insured to institute litigation against the insurer to determine the insurer’s respective rights and duties. Further, when the insurer refuses to tender a defense to its insured or fails to take either of the aforementioned actions, the insurer is barred from disputing policy coverage in a subsequent lawsuit by the insured.<sup>395</sup>

By similar logic, the payer would assert that the non-payer is estopped from denying coverage and must make contribution.

The non-payer would object to the estoppel argument on the following grounds: First, the Illinois precedent is not binding on California courts. Second, the facts are distinguishable in that, in the Illinois case, the *insured*—not a plaintiff in a contribution suit—brought the suit. This is

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393. Estate of Hafner, 229 Cal. Rptr. 676, 691 (Ct. App. 1986).

394. This argument was raised by the payer’s attorney in the contribution suit discussed *supra* note 6. See interview with Robert Schraner, *supra* note 26.

395. Shell Oil Co. v. AC & S, Inc., 649 N.E.2d 946, 949 (Ill. App. Ct. 1995) (citations omitted).

important because of the distinction between a subrogation action (where the insurer “stands in the shoes of the insured”) and a contribution action. If the payer were asserting a subrogation action, the precedent might be applicable, but then the “unclean hands” doctrine would open the fraud question anew.<sup>396</sup> Third, in any case, collusive fraud constitutes a recognized exception to the estoppel rule, as recognized by the California Supreme Court which wrote in a 1959 case,

An insurer that has been notified of an action and refuses to defend on the ground that the alleged claim is not within the policy coverage is bound by a judgment in the action, *in the absence of fraud or collusion*, as to all material findings of fact essential to the judgment of liability of the insured.<sup>397</sup> The insurer is not bound, however, as to issues not necessarily adjudicated . . . .

Rejection of such an estoppel argument finds support in *Andrade v. Jennings*, where the court specifically rejected an argument that the excess insurer was estopped from collaterally challenging a consent judgment by virtue of its absence at the prove-up hearing, holding that the insurer must be given the opportunity to show collusion.<sup>398</sup> Finally, the non-payer would point out that a finding of estoppel requires the showing of detrimental reliance,<sup>399</sup> which the payer presumably could not show.

## 2. Non-Payer Argument

### *a. In a Contribution Action, the Payer Must Demonstrate Two Facts: The Payer Has Paid More than Its Legal Obligation and the Non-Payer Has Paid Less than Its Legal Obligation*

In arguing against automatic contribution, the non-payer would cite the 1990 California case of *United Pacific Insurance Co. v. Hanover*

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396. The “unclean hands” doctrine requires that a plaintiff act “fairly and without fraud or deceit as to the controversy in issue.” *Precision Instrument Mfg. Co. v. Automotive Maintenance Mach. Co.*, 324 U.S. 806, 814-15 (1945). The doctrine of “unclean hands” was offered as a defense by the “non-payer” in the contribution suit discussed *supra* note 6. See Mediation Brief for U.S. Fire Ins. Co. at 5, *New Hampshire Ins. Co. v. National Ben Franklin*, No. BC012590 (Cal. Super. Ct. Feb. 27, 1995), *aff’d*, No. B101206 (Cal. Ct. App. Oct. 29, 1998) (not published). As mentioned, such a defense could be effective only if the payer were suing by subrogation.

397. *Geddes & Smith, Inc. v. Saint Paul-Mercury Indem. Co.*, 334 P.2d 881, 883 (Cal. 1959) (emphasis added).

398. See *Andrade v. Jennings*, 62 Cal. Rptr. 2d 787, 796-97 (Ct. App. 1997).

399. See *Somerset S. Properties, Inc. v. American Title Ins. Co.*, 873 F. Supp. 355, 359 (S.D. Cal. 1994); JERRY, *supra* note 51, § 25E, at 148.

*Insurance Co.*<sup>400</sup> In that case, three insurers allegedly covering a personal injury claim agreed to have an arbitrator apportion liabilities but reserved the right to challenge such apportionment by the judicial process.<sup>401</sup> After each insurer made payment to the injured party in significantly varying amounts in accordance with the arbitration result, each proceeded with a declaratory relief action to challenge the apportionment.<sup>402</sup> The trial court found, however, that none of the insurers had actually been liable on the claim, and it declined to effect any change.<sup>403</sup> The appellate court affirmed, endorsing the trial court view that “[a]bsent a fixed and positive obligation to pay under compulsion, there is no right to contribution.”<sup>404</sup> The appellate court further explained,

Before equity will intervene, a party seeking relief must demonstrate that it has paid more of an obligation than its share while others have paid less than their share. The trial court’s unchallenged findings that no insurer covered the loss leaves no doubt that none of the three insurers can show that any of the others paid less than their share of an “obligation” no one of the three owed.

.... [T]he trial court kept the parties as it found them at the time of judgment.... [N]one of the settling parties had any greater equity than the other, since none covered the loss. As such, the court’s ruling comports well with the traditional equitable maxim, “Between those who are equally in the right, or equally in the wrong, the law does not interpose.”<sup>405</sup>

By the same token, the non-payer would argue that it should not be made to contribute absent a finding that, in denying coverage, the non-payer paid less than its legal obligation.

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400. 266 Cal. Rptr. 231 (Ct. App. 1990).

401. *See id.* at 232-33.

402. *See id.* at 233.

403. *See id.* at 234.

404. *Id.*

405. *United Pac. Ins. Co. v. Hanover Ins. Co.*, 266 Cal. Rptr. 231, 237, 239 (Ct. App. 1990) (citations omitted).



*E. Assuming that Liability Must Be Proven in the Contemplated Contribution Action, Which Party Should Have the Burden of Proof?*

*1. Payer Argument*

*a. Both Reason and Public Policy Support a Presumption in Favor of the Payer Such that the Non-Payer Should Bear the Burden of Proof in a Contribution Action*

The payer would argue that once it makes a prima facie case for coverage, the burden shifts to the non-payer to prove it did not breach its duty to defend. This argument finds some support in *Amato v. Mercury Casualty Co.*,<sup>406</sup> which cites precedent stating,

[I]f the plaintiff produces evidence of the basic or foundational facts, then the burden of proof will shift to the defendant insurers to persuade the trier of fact, by a preponderance of evidence, that [the] settlement did not represent a reasonable resolution<sup>407</sup> of plaintiff's claim or that the settlement was the product of fraud or collusion.

While the cited rule deals with the payment of a claim rather than a contribution action, the payer would argue that it applies equally in the context of a contribution action seeking reimbursement for defense costs.

The non-payer would respond by asserting that the predicate of the above rule has not been met. Rather, the "basic or foundational facts" must be credible and must demonstrate a bona-fide claim. As the California Supreme Court wrote in 1995, "[T]he burden is on the insured to bring the claim within the basic scope of coverage . . . ."<sup>408</sup> Because this "basic scope of coverage" manifestly does not include claims brought through collusive fraud, the stipulated shifting of burden never occurs. By analogy, the payer must carry the initial burden of demonstrating credible facts supporting a duty to defend.

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406. 61 Cal. Rptr. 2d 909 (Ct. App. 1997).

407. *Id.* at 918-19 (quoting *Pruyn v. Agricultural Ins. Co.*, 42 Cal. Rptr. 2d 295, 313-14 (Ct. App. 1995)) (alterations in original).

408. *Waller v. Truck Ins. Exch.*, 900 P.2d 619, 625 (Cal. 1995).

## 2. Non-Payer Argument

### a. *Payer, As the Plaintiff in the Contribution Action, Must Carry the Burden of Proof*

In the 1997 case of *Buss v. Superior Court*,<sup>409</sup> the California Supreme Court addressed a question very similar to the present one, writing,

In a “mixed” action, when the insurer seeks reimbursement for defense costs from the insured, which party must carry the burden of proof?

The answer is: It is the insurer that must carry the burden of proof.

The reason is this. Evidence Code section 500 provides that, generally, a party desiring relief must carry the burden of proof thereon. We can find no exception for<sup>410</sup> an insurer seeking reimbursement for defense costs. We will create none.

By analogy, the non-payer would argue that the payer who “seeks reimbursement for defense costs” must carry the burden of proof.

The payer would reject this analogy, pointing out that the law of contribution is wholly distinct from the law applicable to the reimbursement of non-covered defense costs from the insured. The former reflects purely equitable considerations, while the latter reflects the largely contractual relationship of insurer to insured. Owing to this difference in genesis and purpose, the analogy simply fails.

## IV. PROPOSED RESOLUTION

This final section offers a proposed resolution to the difficult and very important issues discussed in the preceding section.

### A. *An Insurer Does Not Have a Duty to Defend when It “Knows” that the Insured Is Perpetrating Collusive Fraud*

The arguments advanced on behalf of the payer on this issue are not convincing. First, as discussed in Part III.A.1.a, the complaint rule has been abandoned by California. Second, the fact that the duty to defend applies notwithstanding a fraud on the insured is simply not dispositive in the context assumed herein—that of collusive fraud. The reason is simple: In the case of a fraud on the insured, the insured is innocent and has presumably purchased insurance in part to protect against just such an exposure. By contrast, the insured perpetrating collusive fraud on the insurer is engaged in an intentional act, indeed a criminal act. The

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409. 939 P.2d 766 (Cal. 1997).

410. *Id.* at 778. The court went on to identify the standard of such burden of proof as the preponderance of the evidence. *See id.*

obvious lack of mutual assent for such coverage, as well as the language of section 533 of the California Insurance Code, preclude coverage in the context of a fraud on the insurer. Third, the mere convenience of the payer's proposed absolutist rule should not overcome the interests of justice. By the same reasoning, the Supreme Court rejected an absolute rule in favor of a more just rule in connection with obscenity, explaining, "This may not be an easy road, free from difficulty. But no amount of 'fatigue' should lead us to adopt a convenient 'institutional' rationale—an absolutist [view]—[simply] because it will lighten our burdens."<sup>411</sup> The interests of justice demand that the duty to defend be evaluated on a case by case basis, and, where there is collusive fraud, there simply is no duty to defend.

*B. When There Is Substantial Evidence that the Insured Is Perpetrating Collusive Fraud, an Insurer Can Refuse to Defend Without Breaching Any Duty*

Insurance companies perform several important functions for society. First, insurers spread risk by affording coverage to its good-faith insureds. Second, insurance companies provide all the benefits of a commercial enterprise—high-value products for consumers, employment for its workforce, and profits for its investors. To properly fulfill these important functions, insurers must have the discretion to deny non-meritorious claims.<sup>412</sup>

But, what if the insurer is mistaken? What if the "substantial evidence" leads to an incorrect conclusion? What if the insured has not participated in collusive fraud? Even though such mistakes will inevitably occur, there is reason to believe that we are still better off allowing the good-faith insurer to deny highly suspicious claims. A commentator explains,

[In the real world] the insurer must decide how to act on the basis of the only information that it is economical to obtain—the suspicion of fraud by a claims adjuster. The insurer has two pure strategies available. It can ignore the suspicion of fraud and pay all claims, or refuse to pay any claim when a

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411. *Miller v. California*, 413 U.S. 15, 29 (1973).

412. A California appellate court recognized this when it wrote, "Bad faith litigation is not a game, where insureds are free to manufacture claims for recovery. Every judgment against an insurer potentially increases the amounts that other citizens must pay for their insurance premiums." *Dynamic Concepts, Inc. v. Truck Ins. Exch.*, 71 Cal. Rptr. 2d 882, 891 (Ct. App. 1998) (quoting *J.G. Aguerre, Inc. v. American Guar. & Liab. Ins. Co.*, 68 Cal. Rptr. 2d 837, 844 (Ct. App. 1997)).

suspicion of fraud arises. . . .

The pure strategy of ignoring the suspicion of fraud in every case is unlikely to be optimal . . . because fraud would then become . . . rampant . . . . The pure strategy of denying all claims when fraud is suspected will eliminate fraud . . . but at the cost of denying [too many valid claims]. . . . Thus, the best feasible insurance arrangement . . . likely involves the denial of suspicious claims [having a probability of fraud in excess of a certain threshold]. . . .

. . . .  
[S]uppose that insureds with valid claims that have been denied because of a suspicion of fraud will typically file suit. Insureds whose claims are fraudulent, by contrast, will not file suit or will drop the suit in the early stages if it does not result in a quick settlement. Then the willingness of the insured to press the claim to conclusion . . . [may serve as] an efficient screening device.<sup>413</sup>

The same author goes on to explain why litigation may be the most efficient method of resolving suspicious claims.

Insureds whose claims are fraudulent may have good reason to fear that evidence will somehow develop to impeach their factual claims. . . .

. . . In course of informal dealings with the insured, the threat of civil or criminal sanctions for false statements may be quite remote and unlikely to materialize, whereas the likelihood of serious sanction for demonstrably false testimony given under oath may be much greater. An insured involved in formal litigation may thus be more likely to tell the truth. Furthermore, the insurer's ability to investigate the insured's claims effectively may be considerably increased in litigation by the availability of discovery and the prospect of sanctions for plaintiffs who do not comply with discovery requests in good faith.

For these reasons, it is not implausible that insureds who file fraudulent claims will not file suit after they are denied or will drop the case quickly if faced with resistance from the insurer. It is also plausible that sorting cases in this manner, despite the need for the parties to incur significant litigation costs, is nevertheless cheaper and more accurate than the alternatives . . . .

Allowing the insurer the discretion to deny coverage based on substantial evidence of collusive fraud makes sense for several reasons: First, such a rule works to reduce the parasitic burden of fraud on the economy. Second, given the strong disincentives to bad-faith conduct currently afforded by punitive damages, there is little likelihood that such a rule would promote abuse in any appreciable manner. Third, the rule makes sense because the insurer often has no reasonable alternative, due to the requirement in many cases that a declaratory relief action be stayed until the plaintiff's claims have been tried. Finally, the rule makes sense because it is fair. While innocent insureds can still pursue judicial remedies (including punitive damages) when insurers deny coverage, fraudulent insureds attempting to manipulate the system encounter a formidable barrier in the appropriately skeptical non-payer.

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413. Sykes, *supra* note 99, at 426-27, 428-29.

414. *Id.* at 428-29.

*C. The Notion of "Gatekeeper" Duties Has No Basis in Law and Serves No Useful Purpose*

As discussed above, the notion of the payer owing "gatekeeper" duties to the non-payer simply has no basis in law. Moreover, any such duty would be inconsistent with an analogous situation concerning *Cumis* counsel and its relationship to the insurer paying the *Cumis* counsel's bill. Here the courts have held that *Cumis* counsel owes no general duty of care to the insurer.<sup>415</sup> Rather, *Cumis* counsel owes only those specific duties enumerated by statute.<sup>416</sup> Since an insurer cannot sue *Cumis* counsel for negligent handling of a case, by analogy, the non-payer in the contemplated contribution action has no cause of action against the payer.

*D. In Order for the Payer to Prevail in the Contemplated Contribution Action, the Non-Payer Must Be Found to Have Breached Its Duty to Defend*

In any contribution action, the plaintiff must demonstrate four facts: (1) multiple insurers insure the same insured;<sup>417</sup> (2) these multiple insurers insure the same risk (and therefore can be considered equivalent insurers);<sup>418</sup> (3) the plaintiff is one of these equivalent insurers and has paid more than its legal obligation on a covered risk;<sup>419</sup> and (4) the defendant is one of these equivalent insurers and has paid less than its legal obligation on the same covered risk.<sup>420</sup> The non-payer will have paid less than its legal obligation only if it has breached its duty to defend. Accordingly, for the payer to prevail, it must show that the non-payer had a duty to defend and failed to satisfy this duty. Public policy arguments to the contrary are not persuasive, for the reasons cited above.<sup>421</sup>

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415. See *Assurance Co. v. Haven*, 38 Cal. Rptr. 2d 25, 31-32 (Ct. App. 1995).

416. See *id.*

417. See CAL. PRAC. GUIDE INS. LIT., *supra* note 228, ch. 9, § B, at 9:11.

418. See *id.* Note that this requirement precludes contribution in the context where the payer was not legally obligated to defend but the non-payer was so obligated. While the payer might have an action against the non-payer in such circumstances under a theory other than contribution (such as the theory of equitable indemnity), such a discussion lies beyond the scope of this Comment.

419. See *supra* Part III.D.2.a.

420. See *supra* Part III.D.2.a.

421. See *supra* Part III.D.1.a.

*E. The Burden in the Contemplated Contribution Action Should Be Allocated as a Shifting Burden*

*1. Initially, the Non-Payer Must Demonstrate by a Preponderance of the Evidence that Collusive Fraud Did in Fact Occur*

In order to discourage frivolous claims, Rule 9(b) of the Federal Rules of Civil Procedure states, in part, “In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity.”<sup>422</sup> For the same reason, in the contemplated contribution action, the non-payer should be made to demonstrate up-front and with particularity the evidence of collusive fraud.<sup>423</sup> Note, however, an evidentiary aspect of the rule as proposed. The non-payer can attempt to meet this preliminary burden—and the payer can rebut the non-payer’s attempt—by offering any evidence available at the time of the contribution action. In other words, both parties are afforded the benefit of hindsight for the limited purpose of this preliminary test.

Note that this evidentiary rule works as a double-edged sword. Clearly the non-payer can bolster its case by gathering “late” evidence to meet this hurdle. On the other hand, the insurer will be denied a “collusive fraud” defense whenever the facts available at the trial belie an earlier suspicion of collusive fraud. Moreover, the mere absence of *conclusive* facts supporting the claim of collusive fraud at the time of the trial will generally work against the non-payer.

*2. Then, the Non-Payer Must Demonstrate to the Court that the Non-Payer Had, at the Time of the Denial, Specific and Credible Evidence of the Collusive Fraud*

This rule resembles one found in the law of corporations whereby stockholders, suing their corporation for waste and mismanagement, “have the burden of coming forward with specific and credible allegations sufficient to warrant [the] suspicion.”<sup>424</sup> According to this rule, the stockholders (and, by analogy the non-payer) alleging the wrongdoing need not prove the case at this juncture.<sup>425</sup> Rather the stockholders (and, by analogy the non-payer) must demonstrate to the court that the allegations are supported by some real and credible

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422. FED. R. CIV. P. 9(b).

423. Recall that, based on the definition of collusive fraud adopted herein, the sine qua non of collusive fraud is the knowing involvement of the insured in the collusion. For this reason, a scenario involving an innocent insured and his or her fraudulent attorney represents a different circumstance, as discussed *supra* note 298.

424. *Thomas & Betts Corp. v. Leviton Mfg. Co.*, 681 A.2d 1026, 1031 (Del. 1996).

425. *See id.*

evidence.<sup>426</sup> Restricting the evidence to that known at the time of the denial of coverage comports with the well-established rules defining the duty to defend. Accordingly, the non-payer cannot use the benefit of hindsight to justify its decision.

3. *Assuming the Non-Payer Has Met the First Two Burdens, It Must Then Demonstrate to the Court that It Produced a Written Demand for Assurance from the Insured*

This right of reasonable assurance is familiar in the law of contracts. Accordingly, section 2-609(1) of the Uniform Commercial Code provides in part, "When reasonable grounds for insecurity arise with respect to the performance of either party the other may in writing demand adequate assurance of due performance . . . ."<sup>427</sup> While this provision generally serves to protect the vendor in a commercial sale of goods, borrowing the concept for present purposes makes sense. First, insurance policies are contracts. Second, when a good-faith insurer suspects collusive fraud, it certainly has the requisite "reasonable grounds for insecurity" regarding the insured's performance. Third, requiring a demand for assurance in the present context affords the insured the kind of notice universally required in insurance law.<sup>428</sup> Fourth, the demand for assurance and the ensuing response will constitute useful evidence created at the legally critical point in time—i.e., when the non-payer definitively refuses to defend.

The requirement of a written demand for assurance should emphasize substance over form. Any writing which would notify the insured of the insurer's particular "insecurity" should suffice. Thus, if the insurer repeatedly makes inquiries which clearly manifest the insurer's suspicion of collusive fraud, the "demand" requirement will have been satisfied.

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426. *See id.*

427. U.C.C. § 2-609(1) (1962).

428. *See JERRY, supra* note 51, § 111(f), at 750-51. Indeed the insurer must already, by California statute, provide a prompt notice when coverage is denied. *See* CAL. INS. CODE § 554 (West 1993); *Francis v. Iowa Nat'l Fire Ins. Co.*, 297 P. 122, 124 (Cal. Dist. Ct. App. 1931) (finding that an insurer that denied coverage "should have notified the insured so that [the insured] could protect himself by conforming literally to the terms of the contract regarding [the] proof of loss"). Accordingly, the requirement of a demand for reassurance constitutes no significant change from the status quo today in California.

4. *Then, the Non-Payer Must Demonstrate to the Court that the Insured Failed to Act to Dispel the Non-Payer's Concerns in an Objectively Satisfactory Manner*

A corollary of the preceding rule is that the insured's response must be evaluated by the court. If the insured's response provides adequate assurance, the non-payer will not be excused of its duty to defend.<sup>429</sup>

5. *Finally, Assuming the Non-Payer Has Met Its Burdens, the Burden Shifts to the Payer to Demonstrate (by a Preponderance of the Facts) to the Finder of Fact that the Non-Payer Was Nonetheless Not Justified in Denying Coverage—Based on the Standard of a Reasonable and Good-Faith Insurer*

If and only if the non-payer has met each of the preceding four burdens, the burden shifts to the payer as plaintiff to prove its case. As in the case of an insurer seeking reimbursement for defense costs allocable to non-covered claims, the insurer must prove its case by a preponderance of the evidence.<sup>430</sup> This final determination, being predominantly a determination of fact, is made by the trier of fact—typically a jury. The issue for the jury is not whether a fraud has been committed. Indeed that has already been shown by the non-payer in overcoming its first burden. Rather, the jury must determine whether the non-payer's denial of coverage was justified, based *solely* on the evidence the non-payer possessed at the time—including the “demand for assurance” and any responses thereto. In arriving at a decision, the jury should apply the very familiar, albeit nebulous, standards of reasonableness and good faith. Essentially, the jury must decide whether the non-payer conducted itself in a manner commensurate with contemporary expectations of insurance companies. Or, more succinctly: Did it “do the right thing” in denying coverage?<sup>431</sup>

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429. Placing the burden on the non-payer to prove non-cooperation of the insured accords with the prevailing rule in most jurisdictions. See JERRY, *supra* note 51, § 110(d), at 726.

430. See *Buss v. Superior Court*, 939 P.2d 766, 778 (Cal. 1997).

431. Three remaining issues lie beyond the scope of this Comment but warrant brief mention. (1) Once the contribution of defense costs has been resolved, there might also be an issue regarding contribution for any indemnity costs. If the non-payer has prevailed on the issue of defense costs, it will certainly prevail on indemnity costs. This is because the duty to defend is broader than the duty to indemnify. See *supra* Part II.C. If, on the other hand, the payer has prevailed on the issue of defense costs, the non-payer may or may not also be liable for such contribution. (2) Assuming the payer prevails regarding the non-payer's duty to defend, what rule then applies to determine the reasonableness of the defense cost? Should the payer be required to do an extensive accounting of defense costs, or will its actual defense expenditures be presumed



## V. CONCLUSION—APPLYING THE RULE

This Comment has addressed the issues and arguments concerning a contribution action seeking reimbursement of defense costs in the wake of collusive fraud (or the allegation thereof). Part IV proposed a rule of law for deciding such cases. Applying the law to the actual post-Alliance contribution action (which was dismissed on the grounds of the applicable statute of limitations), the trial would proceed as follows: First, the non-payer would presumably have no problem demonstrating, by virtue of evidence available at the time of the trial (including numerous criminal convictions), that the insured had perpetrated collusive fraud. The non-payer would then proceed to reconstruct the scene immediately prior to the denial of coverage, including specific factual details to support its suspicion at the time of collusive fraud. If the court finds such evidence to be not credible, judgment should be awarded forthright to the payer. If, however, the court finds such evidence to be credible, the non-payer would then need to prove that it issued to the insured a written demand for assurance. Assuming it had done so, the court would proceed to evaluate the response of the insured. If the court finds the response to be objectively adequate to allay the non-payer's fears, judgment should be awarded forthright to the payer. If, however, the court considers the response to have been inadequate, the burden would shift to the payer to prove his case to the finder of fact, by a preponderance of the evidence. In this orderly manner, the rule of law would serve justice on the parties to the contribution action. Such a rule of law would also reinforce the proper incentives for insurers. Insurers would be both encouraged to honor bona-fide claims and motivated to assist in society's critical battle against fraud.

GUY WILLIAM MCROSKEY

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reasonable? (3) Finally, to what extent will the findings in the contemplated contribution action constitute collateral estoppel in a subsequent bad-faith action by the insured against the non-payer?

